

Auto Clinic

Breast cancer

Interview protocol

Identification number Card number Trial date

Trial location

In this form you will be asked questions regarding topics surrounding your health status. Use a cross to indicate your answer in the boxes given. Ignore the numbers in the boxes and next to them, they will be used in the further processing of the data. Cross out the 'yes' -box if your answer to the question is yes and the no-box if your answer is no. In some questions you will need to write out your answer. It is important that you attempt to answer all of the questions. Bring the form with you to the check-up. If you have had any difficulties in filling out the form, you can ask for guidance at the trial site. It is extremely important for the trial physician to receive the information acquired in the current form. All material will be processed as private and in full confidence.

Fill in the numeral responses in the following way

If the numbers don't take up the spaces provided, fill in from right to left

Surname

All first names

Date of birth

Social security number

Postal address

Place of birth

Marital status: single married widowed divorced/separated

Occupation

If at home, occupation of partner

If farmer, total area of cultivated land (in hectares)

1. How old were you when you began menstruating?
2. Is your menstrual period regular?
3. Have you already stopped menstruating? If yes, how many years ago?
4. If you have not yet stopped menstruating, what is the length (in days) of your menstrual cycle from the start of your last period to the start of your next period?
5. Birth given times
Miscarried times
Age, when first gave birth
6. Have you breastfed?
If yes, with how many children?
For how long have you breastfed each child on average?
For how long in total?
7. Have you had breast cancer?
If yes, how many years ago were you diagnosed?
In which breast: right left
8. Have you ever discovered lumps in your breasts?
If yes, how many years ago for the first time?
In which breast
Where Indicate underneath
Has the lump grown?
Is or has the lump felt tender?
9. Has there appeared blood stained discharge from your nipple (not during pregnancy or breastfeeding)?
If yes, which breast?
10. Have you noticed your nipples to become inverted recently?
If yes, which one`
11. Have you had inflammation of the breasts during pregnancy or breastfeeding?

At some other time

In which breast

12. Have you had any breast surgery?

If yes, to which breast

How many years ago

For what reason

13. Have you had any damage to your breasts?

What

Which breast

How many years ago

14. Have you had any other but breast cancer (leukemia included)?

If yes, where digestive organs

uterus or cervix

skin

respiratory system

elsewhere

15. Have you had any benign tumors?

If yes, where? skin

hypodermic tissue

elsewhere

16. Do you currently have, or have you previously had goiter

17. Have you suffered from tuberculosis?

If yes, where? Lungs

lymph nodes

elsewhere

18. Have you suffered from any other malignant or chronic infectious diseases?

Which

19. Have you suffered from rheumatic diseases?

20. Have your lymph nodes been swollen?

21. Do you currently receive hormonal treatment for any female-specific diseases

If yes, for what reason?

Name of medication/treatment

22. Have you previously received any hormonal treatment for any female-specific diseases

If yes, for what reason?

Name of medication/treatment

23. Are you currently taking oral contraception?

If 'yes', for how long without stopping?

24. Have you previously been taking oral contraception?

If yes, how many years/months ago

For how long in total?

25. Has there been breast cancer in your family in the parties mentioned below?

(stepmothers and their family not included)

mother

grandmother

mother's sisters

mother's cousins

sister

26. Are you currently pregnant?

If 'yes', in which month?

27. Additional information

Fill at home until this point