

## FNA Questionnaire

Name \_\_\_\_\_ Birth date \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Social Security Number \_\_\_\_\_

Where is your lump? (Please show the doctor) \_\_\_\_\_

How long have you had this lump? \_\_\_\_\_ (days, weeks, months, years)

	YES	NO
Has the lump grown?		
Does the lump hurt?		
Have you ever had cancer?		
If so, have you ever had chemotherapy for treatment of cancer?		
Have you ever had radiation treatment?		
Do you smoke?		
Do you have chronic fever?		
Do you have night sweats?		
Do you have chills?		
Have you lost weight recently?		
For patients with thyroid lumps: Does anyone in your family have thyroid cancer?		

(Questions for women with breast lumps, only)

When was your last period (first day of your last menstrual period)? \_\_\_\_\_

Are you breast feeding/nursing now? Yes No

Do you have breast implants? Yes No

Have you ever had breast surgery? Yes No

Does anyone in your family have breast cancer? Yes No

If yes, who had it? \_\_\_\_\_