Breast Self-examination Questionnaire

*The information you provide here will remain completely anonymous.
Please provide the most appropriate answer for each of the following
questions by drawing a circle around the most appropriate answer.*

1.   Your age (in years): ....

2.   Are you a smoker?   Yes   No

3. Marital status (Tick one):
   - Single
   - Married
   - Engaged
   - Previously married/ divorced

4. Education (Tick highest level applicable to you):
   - Illiterate
   - Primary (Grade 1-5)
   - Middle (Grade 6-8)
   - Secondary (Grade 9 and 10)
   - Higher Secondary (Grade 11 and 12)
   - Graduate degree/college
   - Post graduate degree

5.   a) Have you heard about breast cancer?   Yes   No
        b) Do you believe that breast cancer can be detected early?   Yes   No
        c) Do you believe early detection increases chances of survival? Yes   No
        d) Are you worried about getting breast cancer?   Yes   No

6.   Are you aware of the signs and symptoms of breast cancer?   Yes   No

7.   Have you previously had breast cancer?   Yes   No

8.   Do you have any family history of breast cancer in your
        parents, siblings or children?   Yes   No

9.   a) Have you felt a breast lump/mass or noticed changes
           in your breasts before?   Yes   No
        b) If yes, did you see your doctor about this?   Yes   No

10. If you feel a breast lump or notice changes in your breast in the future
        a) Would you go see your doctor?   Yes   No
        b) Is your usual doctor a female or male?   Female   Male
        c) Would you prefer to see a female doctor for this issue?   Yes   No
        d) Do you feel shy and reluctant to discuss breast health issues? Yes   No

11. Do you feel there is a lack of female doctors or healthcare
        nurses you can go to about breast issues locally   Yes   No

12. Have you heard of breast self-examination?   Yes   No

13. Have you been taught the technique of breast self-examination?   Yes   No

14. Do you palpate your breasts on a regular basis?   Yes   No

a) If Yes, how often? ………………………………………………………………………………..

15. When was the last time you visited your doctor? (Tick one)
   • Within a month
   • Within a year
   • More than a year ago
   • Never

Thank you for completing this questionnaire.