

# Breast Cancer Patient Information Form

**Patient Name** \_\_\_\_\_ **Name you'd like to be called** \_\_\_\_\_

Patient's Age \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work  
Phone \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Do you have any difficulty reading or understanding verbal instructions in English? No Yes

Do you have any difficulty hearing? No Yes

List other languages you speak  
fluently \_\_\_\_\_

Primary care physician \_\_\_\_\_

Other Physicians: 1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_

List person(s) we have permission to speak to regarding your care: name & relationship:

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone \_\_\_\_\_

## **Breast Cancer Screening History:**

Have you been diagnosed with **any other type** of cancer? If yes, what type and at what age were you diagnosed?

Type \_\_\_\_\_ Age \_\_\_\_\_ Type \_\_\_\_\_ Age \_\_\_\_\_

Date of last mammogram \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Where was it completed?  
\_\_\_\_\_

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Are there any other mammograms on file at any other location?      No Yes    Where? \_\_\_\_\_  
 Year \_\_\_\_\_

**Breast Surgical History:** (please circle & fill in date if one of these procedures has been done)

<u>Type of Procedure</u>	<u>Date</u>	<u>Type of Procedure</u>	<u>Date</u>
Biopsy / Aspiration(s)    L    R	_____	Implants                    L    R	_____
Cyst Aspiration(s)        L    R	_____	What type _____	
Lumpectomy/Cancer        L    R	_____	Breast Reduction        L    R	_____
Mastectomy                L    R	_____	Reconstruction         L    R	_____
Name of Surgeon _____		What type _____	

**Have you had any other scans or x-rays performed in the last 10 years?**

**Ordering Physician**

Type _____	When _____	Where _____	_____
Type _____	When _____	Where _____	_____
Type _____	When _____	Where _____	_____
Type _____	When _____	Where _____	_____
Type _____	When _____	Where _____	_____
Type _____	When _____	Where _____	_____
Type _____	When _____	Where _____	_____
Type _____	When _____	Where _____	_____

**MEDICATION LIST** - List all Medications you are currently taking:

<b>Drug/Herbal Name:</b>	<b>Dosage:</b>	<b>Drug/Herbal Name:</b>	<b>Dosage:</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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**ALL ALLERGIES** (including medications) - List all allergies and describe the reaction and severity of the reaction:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you worked with or been exposed to any chemicals?      No Yes

Are you in pain for any reason? No Yes      What pain medicine(s) are you taking? \_\_\_\_\_

Please rate your pain on a scale of 0-10      **1   2   3   4   5   6   7   8   9   10**  
 (0 = NONE and 10 = WORST PAIN)

**Personal Medical History:**

If you have had any of the listed medical conditions **please circle**. Please note your **age** or **year** condition was diagnosed.

Anxiety	Asthma	Coronary Artery Disease	Blood Clots	Migraine Headaches
Depression	Pneumonia	Chest Pain	Colon Polyps	Head injury
Cataracts	Seasonal Allergies	Hyperlipidemia ( <i>high cholesterol</i> )	Ovarian cysts	Car Accidents
Abnormal Bleeding/Bruising	Emphysema	Hypertension (high blood pressure)	Basal cell carcinoma Where?	Hip Fractures
Vertigo	Skin Disorder	Tachycardia (abnormal heart rate)	Radiation therapy	Kidney stones
Strokes	Glaucoma	Diabetes	Restless Leg Syndrome	Renal/Kidney Problems
Seizures	Meningitis	Rheumatoid Arthritis	Sleep Apnea	Rectal bleeding
Neuropathy	Hearing problems	Osteoporosis	Carpal Tunnel Syndrome	Hyperthyroid ( <i>over-active thyroid</i> )
Hepatitis Which type?	GERD ( <i>reflux</i> )	Osteopenia (thinning bones)	Pre-Eclampsia	Hypothyroid ( <i>under-active thyroid</i> )
Herpes - genital	Tinnitus	Osteoarthritis	Hiatal Hernia	

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## Surgical History or Procedures

If you have had any of the following surgeries performed please circle. Also include your **age** or **year** your surgery was performed.

Appendectomy	C-Section	D&C	Tubal Ligation	Port placement
Partial Vaginal Hysterectomy (ovaries remain)	Total Vaginal Hysterectomy (ovaries removed)	Partial Abdominal Hysterectomy (ovaries remain)	Total Abdominal Hysterectomy (ovaries removed also)	Arthroscopic Surgery (where?)
Colonoscopy	Heart Cath/Bypass	Dental implants	Sinus	Tonsillectomy
Cataract Removal R or L eye	Thyroidectomy	Gall Bladder		

## ALL Other Surgical History or Procedures

Please list **all other** surgical procedures.

Procedure	Dr's Name & hospital/clinic performed	Your Age	
Year			
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## Gynecological History

How old were you when you started your menstrual cycle? \_\_\_\_\_

Are you still having menstrual periods? \_\_\_\_\_ If yes, date of last period \_\_\_\_\_

Age at menopause \_\_\_\_\_ Reason \_\_\_\_\_

\_\_\_\_\_

# of pregnancies \_\_\_\_\_ # of live births \_\_\_\_\_ Age at first delivery \_\_\_\_\_ Did you breast feed?  No

Yes

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If yes, how long with 1<sup>st</sup> child? \_\_\_\_\_ 2<sup>nd</sup> child \_\_\_\_\_ 3<sup>rd</sup> child \_\_\_\_\_ 4<sup>th</sup> child \_\_\_\_\_

Have you had a pelvic exam or ultrasound recently? No Yes When \_\_\_\_\_  
Where \_\_\_\_\_

Are you currently taking hormones? No Yes If yes, name: \_\_\_\_\_

Are you currently taking birth control pills? No Yes If yes, name: \_\_\_\_\_

Have you **ever** taken hormones in the **past**? No Yes If yes, name: \_\_\_\_\_

How long did you take them? \_\_\_\_\_

Have you ever taken birth control pills in the past? No Yes If yes, name: \_\_\_\_\_

If yes, how long did you take them?  
\_\_\_\_\_

## Family History

Is your mother alive or deceased? \_\_\_\_\_

If deceased, was she a smoker? No Yes

Did your mother have cancer? No Yes

If yes, at what age was she diagnosed? \_\_\_\_ Type: \_\_\_\_\_

Is your father alive or deceased? \_\_\_\_\_

If deceased, was he a smoker? No Yes

Did your father have cancer? No Yes

If yes, at what age was he diagnosed? \_\_\_\_ Type: \_\_\_\_\_

Do you have sisters and brothers? No Yes

If yes, # of sisters \_\_\_\_\_ # of brothers \_\_\_\_\_

## Family History of Cancer:

Have you had genetic testing done for hereditary cancer? No Yes Results: \_\_\_\_\_

Please note if any **other** family member had cancer and what type: (Breast, Ovarian, Colon, Prostate, Uterine, Cervical, etc)  
If yes, to any, please list their age when diagnosed. *\*This is very important information\**

Sister #1 \_\_\_\_\_ Sister #2 \_\_\_\_\_ Sister #3 \_\_\_\_\_ Sister #4 \_\_\_\_\_

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Brother #1 \_\_\_\_\_ Brother #2 \_\_\_\_\_ Brother #4 \_\_\_\_\_ Brother #5 \_\_\_\_\_

Your Mother \_\_\_\_\_ M. Grandmother \_\_\_\_\_ M. Grandfather \_\_\_\_\_

M Aunt #1 \_\_\_\_\_ M Aunts #2 \_\_\_\_\_ M Aunt #3 \_\_\_\_\_ M Aunt #4 \_\_\_\_\_ M Aunt #5 \_\_\_\_\_

M Uncle #1 \_\_\_\_\_ M Uncle #2 \_\_\_\_\_ M Uncle #3 \_\_\_\_\_ M Uncle #4 \_\_\_\_\_ M Uncle #5 \_\_\_\_\_

Your Father \_\_\_\_\_ P Grandmother \_\_\_\_\_ P Grandfather \_\_\_\_\_

P Aunt #1 \_\_\_\_\_ P Aunt #2 \_\_\_\_\_ P Aunt #3 \_\_\_\_\_ P Aunt #4 \_\_\_\_\_ P Aunt #5 \_\_\_\_\_

P Uncle #1 \_\_\_\_\_ P Uncle #2 \_\_\_\_\_ P Uncle #3 \_\_\_\_\_ P Uncle #4 \_\_\_\_\_ P Uncle #5 \_\_\_\_\_

## Additional information

Are you currently:  Married  Divorced  Widowed  Common Law  
 Single  Separated  Life partner  Legally Separated

Are you sexually active?  No  Yes

Retired:  No  Yes # of years \_\_\_\_\_

Disability:  No  Yes # of years \_\_\_\_\_

Do you have children?  No  Yes How many Children do you have? \_\_\_\_\_

# of boys and ages \_\_\_\_\_ # of girls and ages \_\_\_\_\_

Are you currently working:  No  Yes If working - please *describe your job* \_\_\_\_\_ # of years \_\_\_\_\_

Do you smoke?  No  Yes # of packs a day \_\_\_\_\_ for how many years \_\_\_\_\_

Did you ever smoke?  No  Yes # of years ago that you quit \_\_\_\_\_ # of packs a day \_\_\_\_\_ # years you smoked \_\_\_\_\_

Do you drink alcohol?  No  Yes

Did you ever drink?  No  Yes If yes, how often? \_\_\_\_\_ #drinks per day \_\_\_\_\_ # of days per week \_\_\_\_\_

\_\_\_\_\_ If stopped, list the # of years since you've stopped \_\_\_\_\_

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Would you say your exercise is:

Daily living activities                       Occasional                       Regular                       Running

What type of exercise?                       Yoga                       Walking                       Weight Lifting;  
 Treadmill                       Other \_\_\_\_\_

How Often?                       Daily                       0-1 Days a week                       2-4 days a week

Do you follow any special diet:                       No  Yes    If yes, please  
describe \_\_\_\_\_

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**Religious Preference:** \_\_\_\_\_

**Please list some of your favorite hobbies or pastime activities:**

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With whom do you  
live? \_\_\_\_\_

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Do you feel you have supportive family and friends?                       No  Yes

Is transportation a problem for you?                       No  Yes

Will you need financial assistance/counseling?                       No  Yes

Are you here for a second opinion?                       No  Yes

Who may we thank for your referral?  
\_\_\_\_\_

# Breast Cancer Patient Information Form

Thank you for choosing The Center as your healthcare provider!

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For Doctor use only