

BREAST HEALTH INTAKE FORM

1. Reason for your visit today:

2. Who referred you to see us? _____

3. Who is your primary care physician? _____

4. Are there any other physicians whom you would like to receive today's visit information?

No Yes

Physician name and contact information

Office Number: _____ Fax: _____

Office Address: _____

BREAST HISTORY

1. Please indicate any Breast Symptoms you are currently experiencing:

Mass or Lump: No Yes

Nipple Discharge: No Yes

Skin Changes: No Yes

Other: _____

Breast Pain: No Yes

Duration of symptoms: _____

2. When was your last mammogram? Date: _____ Facility: _____

Have you ever had an irregular finding on your mammogram No Yes

Have you had an ultrasound? Date: _____ Facility: _____

Have you had an MRI? Date: _____ Facility: _____

3. Have you ever had a previous breast biopsy? No Yes Side: Left Right

4. Do you have a history of prior breast cancer? No Yes Side: Left Right

If yes, year diagnosed: _____

How was your prior breast cancer treated? Lumpectomy Mastectomy

Did you have lymph node(s) removed? No Yes Sentinel nodes All lymph nodes

Did you receive radiation therapy? No Yes – If yes, when? _____

Did you receive chemotherapy? No Yes

Did you receive hormone-blocking/endocrine therapy? No Yes

FAMILY HISTORY

1. Are you of Ashkenazi Jewish (Eastern European Jewish) Descent: No Yes
 2. Do you have a **family history of breast cancer**? No Yes Unknown
 3. Do you have a **family history of ovarian cancer**? No Yes Unknown
 4. Do you have a **family history of other cancers**? No Yes Unknown
- If yes to any of the above, please list family members below.

Relative	Maternal or Paternal?	Cancer Type	Age at cancer diagnosis	Current age, if living	Age at death, if deceased

MEDICAL HISTORY

Please list all significant medical diagnoses/conditions:

SURGERIES/HOSPITALIZATIONS

Please list all operations and hospitalizations and date, if applicable:

MEDICATIONS

Please list all medications/vitamins/supplements you are currently taking:

ALLERGIES

Please list all allergies to medications/foods/substances/ what type of reaction you had:

GYNECOLOGIC HISTORY

1. Age at onset of first period? _____ Last menstrual period? _____
2. Have you experienced menopause? No Yes Age at menopause: _____
3. Have you had a hysterectomy? No Yes Removal of ovaries? No Yes
4. How many pregnancies have you had? _____ How many live births? _____
5. How old were you when your first child was born? _____ Did you Breastfeed? No Yes
6. Have you ever had fertility treatments? No Yes
7. Have you ever used hormone-based birth control? No Yes
Age started: _____ Age stopped: _____
8. If post-menopausal, have you ever used hormone replacement therapy? No Yes
Age started: _____ Age stopped: _____

PERSONAL/SOCIAL HISTORY

Ethnicity: Caucasian African American Spanish/Hispanic American Indian/
Aleutian/Eskimo Asian/Pacific Islander Other _____

Marital Status: Single Married Domestic Partnership Divorced Widowed

Do you have children? No Yes

If yes, what are their ages? _____

Are you currently employed? No Yes

If yes, what is your occupation? _____

Are you currently smoking? No Yes

If yes, how much do you smoke? _____ packs/day

If you have quit smoking, how long ago did you quit? _____

How many years did you smoke? _____ How much? _____ pack/day

Do you drink alcohol? No Yes – Number of drinks per day: _____ per week: _____

Describe your daily activity level: (Mark only ONE that best describes you now):

- I am fully active and am able to carry on all usual activities without restriction
- I am restricted in physically strenuous activity, but can walk and am able to carry on light housework
- I can walk and take care of myself, but am unable to carry out work activities
- I need help taking care of myself and I spend more than half of the day in bed or a chair
- I cannot take care of myself at all and spend most of the day in bed

REVIEW OF SYSTEMS:

Please check off below any significant symptoms you have had in the past 6 months:

Constitutional:

- poor appetite
- fatigue
- weight gain/loss
- poor sleep
- fever
- headache

Psychiatric:

- depression
- anxiety

Eyes:

- blurred vision
- double vision
- tearing/watery eyes
- sensitivity to light

Ears, nose, mouth & throat:

- difficulty hearing
- ringing in ears
- sinus problems
- nose bleeds
- dry mouth
- taste changes
- hoarseness
- pain with swallowing
- difficulty with swallowing

Respiratory:

- shortness of breath
- cough
- coughing up blood
- asthma or wheezing

Hematologic/ lymphatic:

- enlarged lymph nodes
- arm swelling
- easy bleeding

Gastrointestinal:

- diarrhea
- constipation
- heartburn or indigestion
- nausea
- vomiting
- blood in stools

Genitourinary:

- frequent urination
- painful urination
- blood in urine
- leakage/ incontinence
- vaginal dryness

Neurologic:

- numbness/tingling
- dizziness
- memory loss
- problems walking/ falls

Cardiovascular:

- irregular heart beat
- rapid heart rate
- chest pain
- swelling of feet/ankles
- heart murmur

Skin:

- itching
- easy bruising
- rash

Endocrine:

- intolerance to heat
- excessive thirst
- hot flashes
- night sweats
- chills

Allergic/ Immunologic:

- allergies
- runny nose
- itchy eyes

Musculoskeletal:

- bone pain
- joint pain
- muscle weakness

Patient Name (print) _____ Signature _____ Date _____ Time _____

Representative Signature _____ Relationship to Patient _____

Interpreter Name & Signature: _____ ID# _____ Date _____