

Date: _____

Name _____ Sex: Female Male
Last First Middle

Date of Birth: _____ Age: _____ Social Security # _____ - _____ - _____

Home Address _____

e-Mail Address _____

Home Phone (____) _____ Cell Phone (____) _____

Business Phone (____) _____ The preferred phone is H C B

Emergency contact: _____ Relationship _____

Address _____ Phone: (____) _____

PCP:

1). Name: _____ Phone: (____) _____

Address: _____

Referring Physician:

2). Name: _____ Phone: (____) _____

Address: _____

Periodic reports may be sent to your Physicians. To which of the above would you like these reports sent?

1). _____ 2). _____ 3). _____

We would like to know how you selected this practice:

- My Physician recommended I come
- I asked my physician to refer me
- I referred myself
- A friend or relative referred me
- Other: _____

REASON FOR SEEKING CARE

1. Check one: Right Left Bilateral

- | | |
|--|---|
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Armpit or axillary mass |
| <input type="checkbox"/> Abnormal mammogram | <input type="checkbox"/> Bloody discharge from nipple |
| <input type="checkbox"/> Lump in breast found by self | <input type="checkbox"/> Inverted nipple |
| <input type="checkbox"/> Lump in breast found by clinician | <input type="checkbox"/> Breast pain or discomfort |
| <input type="checkbox"/> Lump in breast, don't recall who found it | <input type="checkbox"/> Other _____ |

At approximately what date did this symptom (including abnormal mammogram) become apparent to you?

2. Were there any other problems? Choose all that apply.

- | | |
|--|---|
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Armpit or axillary mass |
| <input type="checkbox"/> Abnormal mammogram | <input type="checkbox"/> Bloody discharge from nipple |
| <input type="checkbox"/> Lump in breast found by self | <input type="checkbox"/> Inverted nipple |
| <input type="checkbox"/> Lump in breast found by clinician | <input type="checkbox"/> Breast pain or discomfort |
| <input type="checkbox"/> Lump in breast, don't recall who found it | <input type="checkbox"/> Other _____ |

SMOKING AND ALCOHOL HISTORY

3. Have you ever smoked?

- Yes; but only in the past
- Yes; currently _____ packs per day, since _____
- No;

4. Have you ever or do you currently drink alcohol?

- Yes; but only in the past
- Yes; currently _____ drinks per week, since _____
- No;

5. If you used **estrogen** currently or in the past, what form of estrogen do/did you use? Check ALL that apply.

- A pill
- A patch
- Injection
- Other _____

6. How many total years have you used estrogen?

MEDICAL HISTORY

7. Do you now have, or have you ever had any of the following:

A heart attack?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Heart disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Lung disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
High blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
A stroke, cerebrovascular accident, blood clot or bleeding in the brain, or transient ischemic attack (TIA)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Diabetes or high blood sugar?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Problems with your kidneys?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Alzheimer's Disease, or another form of dementia?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Cirrhosis, or serious liver damage?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
AIDS / HIV?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Leukemia or polycythemia vera?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Lymphoma?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Cancer (other than breast cancer)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Tuberculosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Bleeding tendency or easy bleeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Skin Disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Lumps in breast?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Pain in breast?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Nipple discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Lump in the arm pit?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Recent gain or loss of weight?	<input type="checkbox"/> No Wt. Gain: _____ Wt. Lost: _____

PAST SURGERY/OPERATIONS

8. PLEASE LIST IN CHRONOLOGICAL ORDER:

MONTH	YEAR	TYPE OF OPERATION	REASON FOR SURGERY	HOSPITAL	DOCTOR

MEDICATIONS

9. Please list any medications you are now taking:

	Name of Medication	Dosage	Frequency
Hormones:			
Antidepressent/Antianxiety Pills			
Tranquilizers/Sleeping Pills			
Pain Pills			
Other			

10. Please list or describe any other therapies, vitamins or herbal remedies you are taking currently, why & how you take each (such as frequency and amount). If you need more space, continue on back.

Name of vitamin, herb or therapy: Purpose: Dosage & Frequency Start date:

ALLERGIES

11. Are you allergic to any medicines? Yes No

*If so, please list any medications to which you have had an allergic reaction, and the type of reaction:

12. Are you allergic to any foods? Yes No

*If so, please list any foods to which you have had an allergic reaction, and the type of reaction:

FAMILY HISTORY

Please include only blood relatives, both living and deceased.

13. How many sisters do you have?

14. How many brothers?

15. How many daughters?

16. How many sons?

17. Do you have any blood related family relatives who have been diagnosed with cancer? If yes, please use the chart below to indicate their relationship to you, the type of cancer they have, their age at diagnosis, and whether or not they are still living. Please print the type of relative in the Relative column and the type of cancer in the Cancer Type column

NOTE: If you have more than one relative of a particular type who has been diagnosed with cancer, please assign each a number in the Relative column (e.g. sister 1 and sister 2)

Blood Relative (**see list below)	Maternal or Paternal?	Cancer type (**see list below)	Age at Diagnosis	Is Age Estimated to the Decade?	Alive?
SAMPLE* : Mother	M	Breast Cancer	63	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
				<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
				<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
				<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
				<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
				<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
				<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

18. Please list the age of all people who live with you and their relationship to you. Please include **all** people who share your household, **whether they are blood relatives or not**. If there is more than one person with a particular relationship to you, please assign each a number, e.g. son 1 and son 2.

* For example, if your mother was diagnosed with breast cancer at age 63 and she is still living, you would print Mother in the Relative column, Breast Cancer in the Cancer Type column, 63 in the Age at Diagnosis column, and check off Yes in the Alive column. If you only knew that she was diagnosed sometime in her 60's, you would print 60 in the Age at Diagnosis column and check off the Yes box in the Is Age Estimated to the Decade column.

No household Members

Relationship	Age

Household Members

Mother Aunt Significant Other
Father Uncle Nurse
Sister Grandmother Personal Care Assistant
Brother Grandfather Housekeeping Staff
Daughter Tenant Nanny
Son Roommate Husband

Other (please specify _____)

19. Were any of your grandparents of Ashkenazi Jewish descent?

Yes No Don't know

20. Have you been tested for the BRCA gene mutation?

Yes No Don't know

21. If Yes what was the result: _____

PHYSICAL ACTIVITY

22. Which option below best describes your level of physical activity OVER THE PAST WEEK? Choose one.

- Fully active, able to carry on all usual activities without restriction
- Restricted in strenuous activity; can walk; able to carry out light housework
- Can walk and take care of self; up more than ½ day
- Need some help in taking care of self, spend more than ½ day in bed or chair
- Cannot take care of self at all and spend all my time in bed/chair