

Date: \_\_\_\_\_

Name \_\_\_\_\_ Sex:  Female  Male  
Last First Middle

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Place: \_\_\_\_\_

Mother's Birth Name: \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status:  Single  Married (how long) \_\_\_\_\_  Divorced  Separated  Widowed

Home Address \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Driver's License No. \_\_\_\_\_

Employer/Business Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_

Business Phone (\_\_\_\_) \_\_\_\_\_ If retired or disabled, since when? \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Referring Physician:

1). Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Other Physicians:

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). \_\_\_\_\_

Who is to be billed for your consultation and treatment?

Insurance 1). \_\_\_\_\_

Insurance 2). \_\_\_\_\_

Self Pay \_\_\_\_\_

We would like to know how you selected the

My Physician recommended I come

I asked my physician to refer me

I referred myself

A friend or relative referred me

Other: \_\_\_\_\_

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## **REASON FOR SEEKING CARE**

### 1. Check one.

- |  |   |
|--|---|
| <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 _____                  |

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## **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;

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## **GYNECOLOGIC HISTORY**

### 5. At what age did you have your first period?

- |  |  |
|--|--|
| <input type="checkbox"/> Younger than 11 | <input type="checkbox"/> 14            |
| <input type="checkbox"/> 11              | <input type="checkbox"/> 15            |
| <input type="checkbox"/> 12              | <input type="checkbox"/> 16            |
| <input type="checkbox"/> 13              | <input type="checkbox"/> Older than 16 |

6. How many times have you been pregnant?

7. How many live births have you had?

8. a. If you have children, what was your age at your first time full term pregnancy?

8. b. If you have children, what was your age when you had your last full term pregnancy?

### 9. Have you had a menstrual period within the last six months?

- No (skip to question 11)  
 Yes, natural menstrual periods or menstrual periods on birth control pills  
 Yes, have menstrual periods on hormone replacement therapy  
 Unknown

10. When was your last menstrual period? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

11. If you have NOT had a menstrual period within 6 months, why did your periods stop?

- |   |  |
|---|--|
| <input type="checkbox"/> Pregnancy and/or breast feeding        | <input type="checkbox"/> Hysterectomy, unsure about ovaries    |
| <input type="checkbox"/> Natural menopause                      | <input type="checkbox"/> Both ovaries removed, no hysterectomy |
| <input type="checkbox"/> Hysterectomy with ovaries left in      | <input type="checkbox"/> Chemotherapy or radiation therapy     |
| <input type="checkbox"/> Hysterectomy with both ovaries removed | <input type="checkbox"/> Other _____                           |

12. If you have not had a period within the last 6 months, at what age did you stop having periods? Or, if both ovaries have been removed, how old were you when they were removed?

13. If both ovaries have been removed, what was the date of surgery (month/year)?

14. Have you ever used, or do you use, estrogen or estrogen replacement therapy? Do NOT include birth control pills.

- No, never (skip to question 17)
- Yes, currently
- Yes, in the past

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

- |                                  |  |
|----------------------------------|--|
| <input type="checkbox"/> A pill  | <input type="checkbox"/> Vaginal cream |
| <input type="checkbox"/> A patch | <input type="checkbox"/> Other         |

16. How many total years have you used estrogen replacement?  Year(s)

17. a. Do you use, or have you ever used, birth control pills?

- No, never (skip to question 18)
- Yes, currently
- Yes, in the past
- Not sure

b. If so, for how many years?  Years

18. Have you ever used fertility drugs?

- Yes
- No (If no, skip to question 19)

a. If yes, have you used Clomiphene citrate (i.e. Serophene, Clomid)?

- Yes
- No
- Don't know

b. If yes, have you used an injectable hormone (i.e. hMG, Gonal-F, Follitism)?

- Yes
- No
- Don't know

19. a. Have you ever breast fed?

- Yes
- No (If No, skip to question 20)

b. If yes, how many months (in total) have you breastfed?  Months

c. If yes, how many years (or months) ago did you last breastfeed?  Months or years (please circle)

20. What was the approximate date of your last pelvic exam (internal female exam)?

## MEDICAL HISTORY

### 21. 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 ( <b>other than breast cancer</b> )?	<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**

22. PLEASE LIST IN CHRONOLOGICAL ORDER:

MONTH	YEAR	TYPE OF OPERATION	REASON FOR SURGERY	HOSPITAL	DOCTOR

**MEDICATIONS**

23. Please list any medications you are now taking:

	Name of Medication	Dosage	Frequency
Hormones or Birth Control Pills:			
Antidepressant/Antianxiety Pills			
Tranquilizers/Sleeping Pills			
Pain Pills			
Other			

24. 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:

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**ALLERGIES**

25. 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:

26. 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.*

27. How many sisters do you have?

28. How many brothers?

29. How many daughters?

30. How many sons?

31. 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?
<b>SAMPLE*</b> : 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

\* 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.

32. 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.

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 _____)		

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

Yes       No       Don't know

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

Yes       No       Don't know

35. If Yes what was the result: \_\_\_\_\_

**PHYSICAL ACTIVITY**

36. 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