



Breast Care Patient Questionnaire

Name: _____ Account: _____

Today's date: ____/____/____ Birth date: ____/____/____ Age ____

Height: _____ ft _____ in Weight: _____ lbs.

BREAST HISTORY:

- Reason for visit:
- Symptoms (**see list below**), which **I noted** on routine exam
 - Symptoms (**see list below**), which **my physician** noted
 - Abnormality found on my routine mammogram
 - Second opinion
 - Other: (describe) _____

Symptoms: Please check any symptoms of which you are currently experiencing:

- Abnormal mammogram (breast x-ray)
- Nipple discharge IF YES, PLEASE ANSWER QUESTION BELOW
- Breast lump
- Lump in the axilla (armpit)
- Nipple retraction (nipple sunken into the breast)
- Pain in the breast
- Rash on breast or nipple
- Dimpling of breast skin
- Other: (describe) _____

When did you first become aware of the problem with your breast? _____

If you are experiencing nipple discharge, please check all of the descriptions which apply:

- The discharge is bloody
- The discharge is yellow/green
- The discharge is cloudy
- The discharge is dark
- The discharge happens spontaneously
- The discharge is white
- The discharge happens when pressure is applied

Have you ever had any of the following breast problems?

	YES	NO	DON'T KNOW
Cysts in breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibroadenoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mastitis (infection of milk ducts)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abscess or infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other problems (explain):			

Have you ever had a mammogram Yes No

If yes, list the date and place of your most recent mammogram: _____

Have you ever had a breast biopsy or aspiration? Yes No

If yes, please write the type and side of biopsy, date and results: _____

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SYMPTOMS: Have you currently or recently experienced the following symptoms?

General: Fever Weight loss Weight gain (amount _____)

Night sweats Weakness Poor appetite

Eyes: Blurred vision Double vision Cataracts Glaucoma Spots

Respiration: Cough Chest pain Wheezing Difficulty breathing

Ears: Poor hearing Ringing ears Dizzy

Nose, throat: Sore throat Nasal congestion Nose bleeds Dental problems

Circulation: Angina Palpitations Chest pain with effort

Pounding heart Irregular pulse Swollen feet

Skin: Itching Rash Sores

Digestion: Nausea Heartburn Difficulty swallowing Vomiting

Diarrhea Constipation Hemorrhoids Bleeding

Genitourinary: Stones Infections Dark or bloody urine Leaking urine

Joints/muscles: Back pain Swollen joints Joint pain (where _____)

Emotions: Nervous Change in sleep Tearful Depressed

Blood: Anemia Blood clots Blood transfusions Easy bruising

Pain Location: _____ Duration: _____

 What makes it better? _____

 What makes it worse? _____

MENSTRUAL HISTORY:

How old were you when your periods began? _____ years old

Do you currently have menstrual periods?

Yes, regularly every _____ days Yes, irregularly No

If yes, when did your last period begin? _____

If no, how old were you when your periods stopped and why? _____ years old

Natural change of life (menopause) Removal of uterus (hysterectomy)

Chemotherapy Removal of ovaries (oophorectomy)

Pregnancy Don't know

PREGNANCY HISTORY:

Total number of pregnancies: _____ (Include live births, abortions, stillbirths, and miscarriages)

Total number of live births: _____ Age at first pregnancy _____

Total number of children breast fed for longer than two months: _____

HORMONAL HISTORY:

Have you ever taken birth control pills or patches for more than 3 months? Yes No

Have you ever taken hormones other than birth control pills? Yes No

(for example, estrogen, Premarin, progesterone – including shots, patches, pills)

If yes, which ones and for how long: _____

If yes, are you using them now? _____

If yes, and you have stopped, why did you stop? _____

Do you have any symptoms of hormone loss/menopause? _____

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MEDICAL HISTORY:

Please check the boxes below if you have been treated or have any of the following medical conditions:

- High blood pressure
- Heart attack
- Congestive heart failure
- Stroke
- Peptic ulcer disease
- Hiatal hernia
- Any tumor (not breast cancer)
- Chronic obstructive pulmonary disease (COPD)/Emphysema
- Peripheral vascular disease/circulation problems
- Other medical problems: (describe): _____

- Thyroid problems
- Diabetes (on medication/insulin)
- Diabetes with eye/kidney problems
- Hepatitis
- Leukemia or polycythemia veria
- Lymphoma
- HIV

- Seizures
- Frequent headaches
- Asthma
- Rheumatoid Arthritis
- Fibromyalgia
- Bleeding disorders
- Depression

Have you had a cancer (other than breast cancer) Yes No

If yes, what type and date of diagnosis: _____

If yes, how was the cancer treated: Chemotherapy Radiation Surgery

Have you been previously diagnosed with breast cancer? Yes No

If yes, describe the side, type, date of diagnosis, and treatments: _____

SURGICAL HISTORY:

Please list all previous surgical procedures and dates, including outpatient and inpatient procedures, colonoscopy, etc.

Have you had any problems with anesthesia? Yes No

Do you have any dental problems? Yes No

Missing teeth: _____ Dentures: upper _____ lower _____ Dentist: _____

ALLERGIES: (list medication and type of reaction): _____

CURRENT MEDICATIONS:

Please list all your current medicines, including over-the-counter, prescriptions, vitamins, and supplements:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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FAMILY HISTORY:

Has your mother ever had **breast cancer**? Yes No

If yes, how old was your mother when she was diagnosed with breast cancer? _____

How many sisters do you have? _____ Do any of them have breast cancer? Yes No

Number of sisters with cancer _____ Age when cancer(s) found _____

Have any other relatives had **breast cancer**? Yes No

If yes, please list: _____

Have any relatives had **prostate cancer**? Yes No

If yes, please list: _____

Have any relatives had **ovarian cancer**? Yes No

If yes, please list: _____

Is there any other **family history of cancer**? Yes No

If yes, please explain: _____

Is there any other family history of any medical problems? (heart disease, stroke, etc.) _____

MISCELLANEOUS:

Have you used any of the following currently or in the past?

- Alcohol If yes, how much/how often? _____
- Tobacco How many packs per day for how many years? _____ Stopped smoking _____ years ago
- Smokeless tobacco How much/how often? _____
- Caffeine How much/how often? _____ Recreational drugs _____

Describe your daily activity level:

- I am fully active, able to carry on all usual activities without restriction.
- I am restricted in physical activity, but I can walk and am able to do light housework.
- I can walk and take care of myself, but I 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.

Do you use any of the following? Cane Walker Wheelchair Oxygen

Describe your current employment status: What is your occupation? _____

- I am employed more than 32 hours per week. I am retired.
- I am employed less than 32 hours per week. I am disabled.
- I am a full-time or part-time student. I am unemployed, seeking work.
- I am a homemaker full-time. I am on medical leave.

Marital status: M D S W Who lives with you? I live alone Spouse Children Friend

Who helps you at home?

Race (select all that apply): White Black or African American American Indian or Alaska Native

Asian Native Hawaiian or Other Pacific Islander Unknown Decline to Answer

Ethnicity (select one): Not Hispanic or Latino/a Hispanic or Latino/a Unknown Decline to Answer

The amount of schooling completed: Some high school High school graduate Some college

Vocational or technical school beyond high school College graduate Post-graduate degree

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Who is your **primary doctor**? _____

When was your last doctor's visit? _____

Who is your **gynecology care provider**? _____

When was your last check-up? _____

Who referred you to us?

- Mammography department
- Myself
- Other _____
- A former patient
- A physician _____

What **pharmacy/drug store** do you use? _____

Address/Phone number if known: _____

Have you executed a Durable Power of Attorney, Directive to Physician, or Living Will? Yes No

Would like more information regarding these documents? Yes No

Please give the name and number of a contact person in case we cannot reach you at home:

Name _____ Phone _____

Are we authorized to speak to this person about your medical condition? Yes No

Are there additional people we are authorized to speak to about your condition? Yes No

If yes, name of person(s), include relationship and contact phone number:

Name _____ relationship _____ Phone _____

Name _____ relationship _____ Phone _____

Name _____ relationship _____ Phone _____

Name _____ relationship _____ Phone _____

Do you wish to restrict access to your health information? **Yes (see line below)** No

If yes, please obtain *Restriction Request Form* from the receptionist.

Do you have any concerns about health insurance coverage? Yes No

Do you need to have a referral from your primary care physician? Yes No

If yes, did you bring a referral with you? Yes No

Do you have a Drug Reimbursement Plan? Yes No

Home phone: _____ Work phone/Cell: _____ Other msg. Phone: _____

Signature of Patient/Guardian: _____

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