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	❑	❑	❑
Fibroadenoma	❑	❑	❑
Mastitis (infection of milk ducts)	❑	❑	❑
Abscess or infection	❑	❑	❑

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)
- ❑ 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
- ❑ Chronic obstructive pulmonary disease (COPD)/Emphysema
- ❑ Peripheral vascular disease/circulation problems
- ❑ Other medical problems: (describe): _____

_____

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 and prescriptions.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

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

What is your race or ethnic origin?

- ❑ White/Caucasian ❑ African-American ❑ Asian or Pacific Islander
- ❑ Hispanic/Spanish ❑ Native American/Eskimo ❑ Other

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
- ❑ A former patient
- ❑ Myself
- ❑ A physician _____
- ❑ Other _____

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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