The Breast Surgeons at the Helen F. Graham Cancer Center

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NAME: _____AGE:_____BIRTHDATE: _____APPOINTMENT DATE:_____

REASON FOR VISIT: _____ Pharmacy Name and Phone# _____

Who referred you today? _____

Primary Care Doctor: _____OB-Gyn: _____Oncologist: _____

Circle breast symptoms that you currently have: mass pain armpit lumps skin changes nipple discharge
Do you check your own breasts? ____No _____Yes (how often?) _____

Age first period: _____ Date of Last Period: _____ Age at Menopause: _____ Bra Size: _____
Number of Pregnancies:_____ Number of children: _____ Age at first delivery: _____ Breast Fed: __yes __no

Current birth control: _____ Years taken:_____ Past Birth Control used: _____Years: ____ Stopped:___
Hormone Replacement: __no, never. __yes, currently __yes, in the past. Medication Name: _____Years:_____

Blood thinners? __yes __ no Daily aspirin? __yes __ no
Year of last: Colonoscopy: _____Bone density scan: _____ Mammogram: _____ Pap/Pelvic exam: _____

ALLERGIES: Are you allergic to Medication (pls. circle): No / Yes Name: _____
Latex (pls circle) : Yes / No Adhesive (pls circle): Yes / No Other Allergies:_____
What happens? __rash/hives, __ nausea/ vomiting, __ shortness of breath, __ anaphylaxis, __ Other _____

Genetic Testing: ___Yes ___ No Lab/Year/Result_____
Ashkenazi Jewish Heritage: ___Yes __No

Are you having any pain today? ___ Yes ___ No Where: _____
On a scale of 0 to 10 (0 = No pain 10 = Worst Pain), What number would you give your pain? _____

BREAST HISTORY: Please check all that apply to you:

__ Breast Aspiration ____Right ____ Left
__ Core (Needle) Biopsy ____Right ____ Left
__ Excisional (Surgical) Biopsy ____Right ____ Left
__ ADH/ALH Breast (___Atypical Ductal/ Lobular Hyperplasia)
__ Reduction Mammoplasty (Breast Reduction) ____Right ____ Left ____Both
__ Breast Augmentation ____Both ____Right ____ Left ___Saline ___Silicone
__ Partial Mastectomy (Lumpectomy) ____Right ____ Left
__ Breast Radiation ____Right ____ Left
__ SAVI catheter placement ____Right ____ Left
__ Sentinel Lymph Node Biopsy ____Right ____ Left
__ Axillary Lymph Node Dissection ____Right ____ Left
__ Mastectomy ____Right ____ Left
__ Implant Reconstruction ____Right ____ Left ___Saline ___Silicone
__ TRAM / DIEP / Latissimus Dorsi Flap ____Right ____ Left
__ Port Placement ___Port Removal

OTHER MEDICAL HISTORY: Please check all that apply to you:

__ Anemia
__ Angina Pectoris - chest pain
__ Anxiety
__ Atrial Fibrillation. -irregular heart beat
__ Asthma
__ Arthritis: ___Rheumatoid ___Osteo
__ Blood Transfusions
__ Cancer – Colon
__ Cancer – Ovarian
__ Cancer – Prostate
__ Cancer – Skin
__ Cancer – Uterine
__ Cancer – Other _____
__ Chronic Bronchitis/cough
__ Chronic Renal (Kidney) Insufficiency /Failure
__ Claustrophobia
__ CHF (Heart Failure)
__ COPD
__ Coronary Artery Disease (Heart Disease)
__ Crohn's Disease
__ CVA/TIA (Stroke)
__ Depression

__ Diabetes Type 1
__ Diabetes Type 2
__ Dialysis ___Hemodialysis ___Peritoneal
__ Fibrocystic change-breast
__ GERD (Heartburn/Reflux)
__ GI bleed (internal bleed)
__ Heart murmur
__ Hepatitis: __C __B __ other
__ HIV Infection
__ Hypercholesterolemia (high cholesterol)
__ Hypertension (high blood pressure)
__ Hypotension (low blood pressure)
__ Hypothyroidism (Low Thyroid)
__ Hyperthyroidism (High Thyroid)
__ Infertility
__ Irritable Bowel Disease (IBS)
__ Kidney stone
__ Liver disease
__ Lupus
__ Migraines
__ Multiple Sclerosis
__ MI (heart attack)
__ Osteopenia
__ Osteoporosis
__ Peripheral Vascular Disease
__ Platelet disorder (Bleeding disorder)
__ Scleroderma
__ Seizure Disorder
__ Sickle Cell Anemia
__ Sickle Cell Trait
__ Thrombophlebitis (blood clots)
__Transplant Recipient- type/date_____

SURGICAL HISTORY: Please check all that apply to you and add DATE of procedure:

__ CABG (Open Heart)
__ Cardiac (Heart)Stents
__ Cardiac Cath (Percutaneous Angioplasty)
__ Cardiac Pacemaker (Type?_____)
__ Valve Replacement
__ Vascular Surgery
__ Pulmonary (Lung) Surgery
__ Abdominoplasty (Tummy Tuck)
__ Appendectomy
__ Cholecystectomy (removal of gall bladder)
__ Gastric Band/Sleeve/Bypass
__ Hernia Repair: Location_____
__ C-Section _____
__ Hysterectomy (Removal of uterus)
__ Hysterectomy w/USO (Removal of 1 ovary)
__ Hysterectomy w/BSO (Removal of both ovaries)
__ Tubal Ligation
__ Urinary Incontinence Surgery
__ Uterine Ablation

__ Amputation
__ Back Surgery
__ Craniotomy (Brain Surgery)
__ Joint Replacement Location: _____
__ Orthopedic Surgery – UE (Upper body):_____
__ Orthopedic Surgery – LE (Lower body):_____

__ Nephrectomy (Removal of kidney)
__ Thyroid Resection (Surgery on the Thyroid)
__ Parathyroidectomy (Removal of parathyroid)

__ Other _____
__ Other_____

Do you have a history of problems with anesthesia: __ yes ___ no
Have you ever had any significant bleeding *after* surgery? _____

FAMILY MEDICAL HISTORY: (does not include the patient): Please check all that apply

___ Anemia __ Anesthesia Problems __ Blood Clots/bleeding issues __ Stroke __ Heart attack (<55 male)
___ Diabetes __ High blood pressure __ Osteoporosis __ Seizures __ Heart attack (<65 female)

Please list any cancers in your family (PLEASE INCLUDE YOUR SIBLINGS AND CHILDREN ON EITHER SIDE):

Mother's Family Cancer History:			**Father's Family Cancer History:**		
Type:	Relation to you:	Age at Diagnosis:	Type:	Relation to you:	Age at Diagnosis:

SOCIAL HISTORY:

Marital Status: _____ Employment status: _____ Occupation (include even if retired): _____
With whom do you currently live?: _____

SMOKING:

Never smoked Current smoker (Years: ____ Packs Per Day: ____ Everyday ____ Occasional ____)
Former smoker, Year Quit _____ How many packs per day? _____ For how long? _____

Alcohol Use: __ Yes __ No __Past How much? _____ How often? _____
Drug Use: __ Yes __ No __Past How much? ____ How often? _____ Drugs used _____
Regular exercise: __ Yes __ No What type? _____ How often? _____
History of Domestic Abuse: __ Yes __ No __Past Do you currently feel safe at home? __ Yes __ No
Diet: __ Regular __ Diabetic __Vegetarian/Vegan Other: _____