



Name: _____ Date: _____

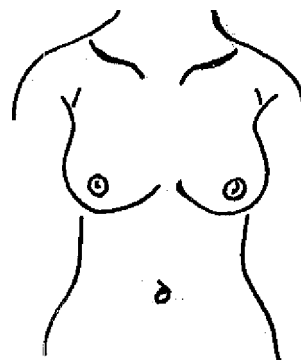
Height: _____ Weight: _____ Age: _____

Referring Physician : _____

Please list any recent biopsies, scans, x-rays, or other tests related to your present breast diagnosis:

Indicate the involved area(s) of your breast(s) or site(s) of previous breast surgery.

<i>Procedure</i>	<i>Date</i>	R	L
_____	_____		
_____	_____		
_____	_____		
_____	_____		



Bra/Cup Size (e.g. 34B) _____ Has this changed in the last year: Y / N
 Number of pregnancies: _____ Age at 1st menstrual period: _____
 Number of children: _____ Age at 1st full-term pregnancy: _____
 Able to breast feed: _____

Have you had a menstrual period within the last six months? _____ Yes, Regular _____ Yes, Irregular _____ No

If you have not had a period within the last six months, please indicate why your periods have stopped:

- | | |
|--|---|
| _____ Pregnancy and/or breast feeding | _____ Natural menopause (Age: _____) |
| _____ Hysterectomy, ovaries left in (Date: _____) | _____ Hysterectomy, both ovaries removed (Date: _____) |
| _____ Hysterectomy, unsure about ovaries (Date: _____) | _____ Both ovaries removed, no hysterectomy (Date: _____) |
| _____ Chemotherapy, radiation, or hormonal therapy | _____ Other, please specify: _____ |

Are you currently using birth control pills? _____ No _____ Yes If yes, how many years? _____

Did you ever use hormones after menopause? _____ No _____ Yes If yes, how many years? _____

Age at first Mammogram: _____ Number of mammograms to date: _____

Date of last Mammogram: _____ Result: _____

Have you been told that you have fibrocystic breasts? _____ No _____ Yes

Have you had previous breast surgery(s)?: _____ No _____ Yes If Yes, please explain _____

Do you have any of the following symptom associated with the breast(s):

(please check)	No	Yes	Right	Left	Both
Breast pain	_____	_____	_____	_____	_____
Rashes under breasts	_____	_____	_____	_____	_____
Shoulder Straps grooving	_____	_____	_____	_____	_____
Neck Pain	_____	_____	_____	_____	_____
Upper back pain	_____	_____	_____	_____	_____
Lower back pain	_____	_____	_____	_____	_____
Absent or diminished nipple sensation	_____	_____	_____	_____	_____

Are any of these symptoms being treated? _____

Is there any history of breast cancer in your family: No Yes

If yes, Relative: Mother: _____ Sister(s) _____ Other _____
Maternal Grandmother _____ Paternal Grandmother _____

Have you ever had radiation treatment to your breast or chest wall No Yes

Explain: _____

Are you a current smoker? No Yes Packs/Day _____ Total years: _____
Do you drink alcohol? No Yes How much daily? _____
Do you have any allergies to medications? No Yes Explain: _____

Please indicate any previous, ongoing or planned therapy for breast cancer:

Chemotherapy Radiation Therapy
 Tamoxifen Other Hormone therapy
 Other: _____

Please list any previous surgical procedures (not related to current breast diagnosis):

Procedure	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list current medications, vitamins, and herbal supplements used on a regular basis:

Medication or Compound	Date & Schedule
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please List any other medical conditions (such as heart attacks, high blood pressure, diabetes, blood clots, etc.):

Description:	Date of onset or age	Currently treated
_____	_____	No <input type="checkbox"/> Yes <input type="checkbox"/>
_____	_____	No <input type="checkbox"/> Yes <input type="checkbox"/>
_____	_____	No <input type="checkbox"/> Yes <input type="checkbox"/>
_____	_____	No <input type="checkbox"/> Yes <input type="checkbox"/>
_____	_____	No <input type="checkbox"/> Yes <input type="checkbox"/>

What is your occupation? _____

Please indicate current employment status (choose only one):

Employed greater than 32 hours/week On medical leave
 Employed less than 32 hours/week Disabled
 Full time student Unemployed and/or seeking work
 Part time student Retired
 Employed less than 32 hours and a student Other: _____
 Homemaker

Please choose on option that best describes your current level of activity:

Fully active, able to carry on all usual activities without restrictions
 Restricted in physically strenuous activity, but can walk and is able to carry out light housework.
 Can walk and take care of self, but is unable to carry out any work activities. Up more than half a day.
 Needs some help taking care of yourself, spends more than half a day in bed or in a chair.
 Cannot take care of yourself at all and spends all of your time in a bed or chair.