PATIENT INFORMATION FORM

Today's date: __ __/__ __/__ __ __ __ (month/day/year)
Date of birth: __ __/__ __/__ __ __ __ (month/day/year)

(Consent)

1. Have you had any of the following breast changes in the last 3 months? *(check all that apply)*

	Both	Left	Right
Lump	☐	☐	☐
Nipple discharge	☐	☐	☐
Pain	☐	☐	☐
Other, describe:________________	☐	☐	☐

☐ No changes

2. What is the main reason for your visit today? (*check one*)
☐ Routine screening
☐ Follow-up to routine screening exam
☐ Concerns about breast problems
IF CONCERNS:Who first noticed your breast problems? ☐ Self
☐ Physician or other healthcare provider
☐ Other

3. When was your last mammogram?
Date: __ __/ __ __ __ __ (month/year)
☐ I never had a mammogram

4. When did a health care provider last examine your breasts?
☐ Never
☐ Within the last 3 months
☐ 4 months to 1 year ago
☐ More than 1 year ago
☐ Not sure

5. Have you ever been diagnosed with breast cancer?
☐ No ☐ Yes
IF YES, please answer the following questions:
Which breast(s)? ☐ Left ☐ Right ☐ Both
At what age were you first diagnosed? __ __ years old
OR: Date of diagnosis: __ __ / __ __ __ __ (month/year)

6. Have you had any of the following breast procedures? *(check all that apply)*

	Left	Right	Both
Fine needle or cyst aspiration	☐	☐	☐
Biopsy	☐	☐	☐
Lumpectomy (for breast cancer)	☐	☐	☐
Mastectomy	☐	☐	☐
Radiation therapy	☐	☐	☐
Breast reconstruction	☐	☐	☐
Breast reduction	☐	☐	☐
Breast implants (still present)	☐	☐	☐

☐ I have not had any of the above procedures

7. Have any blood relatives been diagnosed with breast cancer?

Mother:	☐ No	☐ Yes	☐ Not sure	
Sister:	☐ No	☐ One	☐ 2 or more	☐ Not sure
Daughter:	☐ No	☐ One	☐ 2 or more	☐ Not sure

IF YES, were any diagnosed before age 50?

Mother:	☐ No	☐ Yes	☐ Not sure	
Sister:	☐ No	☐ One	☐ 2 or more	☐ Not sure
Daughter:	☐ No	☐ One	☐ 2 or more	☐ Not sure

8. Have you or a blood relative ever been diagnosed with ovarian cancer?
☐ No
☐ Self
☐ Mother, sister, or daughter
☐ Other relative
☐ Not sure

9. How old were you when you had your first period?
☐ 12 or younger
☐ 13
☐ 14
☐ 15 or older
☐ Not sure
☐ Never started my period

10. Are you currently taking any of the following hormone medications? *(check all that apply)*
☐ Hormone replacement therapy (HRT) (e.g. Premarin)
IF HRT: ☐ Estrogen ☐ Progesterone ☐ Both
☐ Tamoxifen (Nolvadex)/Raloxifene(Evista)
☐ Hormones for birth control
☐ Other hormone: ________________________
☐ I am not currently taking hormone medication

11. Have your menstrual periods stopped permanently? *(check one)*
☐ No
☐ Yes, natural menopause
☐ Yes, surgical procedure
☐ Yes, other reason
☐ Not sure
IF NO or NOT SURE, when was the first day of your last period? __ __/__ __/__ __ __ __ (month/day/year)
IF YES, age at last period: __ __ years old

12. Have you ever given birth?
☐ No ☐ Yes
IF YES: How old were you when your first child was born? __ __ years old

13. What is your current height? __ feet __ __ inches

14. What is your current weight? __ __ __ pounds

15. Are you of Hispanic, Spanish, or Latino origin?
☐ No ☐ Yes

16. What is your racial or ethnic background? *(check all that apply)*
☐ White
☐ Black or African American
☐ Asian
☐ Native Hawaiian or other Pacific Islander
☐ American Indian or Alaska Native
☐ Other, describe: ______________________

17. What is the highest level of education you have completed? *(check one)*
☐ Less than high school graduate
☐ High school graduate or GED
☐ Some college or technical school
☐ College or post-college graduate

18. What kind of healthcare coverage do you have? *(check all that apply)*
☐ Medicare ☐ Medicaid ☐ Private insurance
☐ Managed care (such as HMO or PPO)
☐ Other, describe: ______________________
☐ Not sure
☐ I have no coverage

Thank you for taking time to complete this questionnaire.