

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

	Both	Left	Right
Lump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nipple discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, describe: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biopsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lumpectomy (for breast cancer)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mastectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast reconstruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast reduction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast implants (still present)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 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

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

(Consent)

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.