BREAST CARE
of WESTERN NEW YORK
A Roswell Park Community Cancer Practice

BREAST CLINICAL HISTORY AND RISK EVALUATION FORM

Today's Date:_____ Name:_____ Date of Birth: _____

Address:_____

Home Phone: _____ Cell Phone: _____

VITALS (TO BE COMPLETED BY OFFICE STAFF)

Height: _____ Blood Pressure: _____ Pulse: _____

Weight: _____ Temperature: _____

MEDICAL HISTORY: TO BE COMPLETED BY PATIENT

PLEASE DESCRIBE THE MAIN REASON FOR YOUR VISIT/REFERRAL:

_____

WHAT WAS YOUR FIRST INDICATION OF YOUR CURRENT BREAST PROBLEM?

- ☐ A problem identified by mammogram
- ☐ Bloody discharge from nipple
- ☐ Lump in breast that you discovered
- ☐ Lump in breast that your physician discovered
- ☐ Mass in armpit (axilla)
- ☐ Inverted nipple
- ☐ Breast pain or discomfort
- ☐ Other_____

WHAT WAS THE DATE THIS PROBLEM WAS *NOTED?* ___ /___ /___

CONCERNING YOUR CURRENT BREAST PROBLEM, DID YOU HAVE A BREAST BIOPSY OR SURGERY?

___ Yes ___ No If Yes, what side? ___Left ___Right ___Both

Date of Biopsy or Surgery: ___ /___ /___ Place of Biopsy: _____

HAVE YOU HAD A MAMMOGRAM? ___Yes ___No If yes, most recent date: ___ /___ /___ Where?_____

PLEASE LIST THE NAMES OF YOUR CURRENT PHYSICIANS:

PCP: _____ OB/GYN: _____

Specialists: _____

Pharmacy: _____

Pharm. Address: _____ Pharm. Phone: _____

PLEASE LIST PREVIOUS HOSPITALIZATION(S) INCLUDING YEAR AND REASON:

Where hospitalized	When	Reason for Hospitalization

PLEASE LIST PREVIOUS SURGERIES (ambulatory and inpatient) INCLUDING YEAR AND REASON:

Type of previous surgery	Year of previous surgery

CURRENTLY DO YOU SMOKE? ___Yes ____No If yes, how much? _____

FORMER SMOKER? ___Yes ____No If yes, How many years did you smoke? _____

DO YOU DRINK ALCOHOL? ___ Yes ____ No If yes, how much do you drink? _____

DO YOU DRINK CAFFEINE? ___ Yes ____ No If yes, how much do you drink? _____

DO YOU USE DRUGS? ___Yes ____ No If yes, what kind? _____

GYNECOLOGIC HISTORY

WHEN DID YOUR MENSTRUAL PERIODS BEGIN? Age _____ Never _____

HOW MANY PREGNANCIES HAVE YOU HAD? _____ NUMBER OF LIVE BIRTHS? _____

HOW OLD WERE YOU WHEN YOUR FIRST CHILD WAS BORN? _____

HAVE YOU EVER TAKEN BIRTH CONTROL PILLS? ___Yes ___No

IF YES, HOW MANY YEARS? _____

HAVE YOU HAD A PERIOD IN THE LAST SIX MONTHS?

- ☐ No
- ☐ Yes, natural periods or menstrual periods on birth control
- ☐ Yes, have menstrual periods on hormone replacement therapy

IF YOU HAVE NOT HAD A MENSTRUAL PERIOD WITHIN THE LAST SIX MONTHS, WHY HAVE YOUR PERIODS STOPPED?

- ☐ Pregnancy and/or breastfeeding
- ☐ Hysterectomy, ovaries left in
- ☐ Hysterectomy, both ovaries removed
- ☐ Hysterectomy, unsure about ovaries
- ☐ Both ovaries removed, no hysterectomy
- ☐ Chemotherapy, radiation therapy or hormone therapy
- ☐ Natural menopause
- ☐ Other, please specify _____

IF YOU HAVE REACHED MENOPAUSE, HOW OLD WERE YOU? _____

IF YOU HAD BOTH OVARIES SURGICALLY REMOVED, WHAT WAS THE DATE? _____

HAVE YOU RECEIVED CHEMOTHERAPY, HORMONE THERAPY (excluding Tamoxifen) OR RADIATION THERAPY DURING THE LAST MONTH? ___Yes ___No

HAVE YOU EVER HAD ESTROGEN REPLACEMENT THERAPY? ___Yes ___No

IF YES, HOW MANY YEARS HAVE YOU BEEN ON ESTROGEN REPLACEMENT THERAPY? _____

DEMOGRAPHIC DATA

ARE YOU PRESENTLY EMPLOYED? ___Yes ___No

Occupation: _____

Employer: _____

IF UNEMPLOYED? (please choose only one):

- ☐ Student
- ☐ Homemaker
- ☐ Disabled
- ☐ Retired
- ☐ Other _____

RACIAL BACKGROUND:

- ☐ Unknown
- ☐ Caucasian
- ☐ African American
- ☐ Asian or pacific islander
- ☐ American Indian, Aleutian, Eskimo
- ☐ Spanish/Hispanic
- ☐ Other

PLEASE REVIEW THE LIST BELOW. CHECK THE RELATIONSHIP OF THAT PERSON TO YOU, LIST THEIR TYPE OF CANCER AND AGE AT DIAGNOSIS (if known) ***Maternal = Mother's side / Paternal = Father's side***

Relative	Type of Cancer	Age at Diagnosis
Mother		
Father		
Sister(s)		
Brother(s)		
Son(s)		
Daughter(s)		
Maternal Grandmother		
Maternal Grandfather		
Maternal Great Grandmother		
Maternal Great Grandfather		
Maternal Aunt(s)		
Maternal Uncle(s)		
Maternal Cousin(s)		
Paternal Grandmother		
Paternal Grandfather		
Paternal Great Grandmother		
Paternal Great Grandfather		
Paternal Aunt(s)		
Paternal Uncle(s)		
Any Other Relative(s)		

MEDICATIONS

ARE YOU ALLERGIC TO ANY MEDICATION? ___Yes ___ No

Which?: _____

_____

PLEASE LIST MEDICATION THAT YOU ARE CURRENTLY TAKING INCLUDING OVER-THE-COUNTER MEDICATIONS AND MEDICATIONS THAT YOU TAKE ONLY OCCASIONALLY:

_____

_____

_____

_____

_____

_____

PRIOR TO YOUR **CURRENT** PROBLEM, HAVE YOU EVER BEEN DIAGNOSED WITH BREAST CANCER?

____Yes ____No ____ Unknown

If yes, date first diagnosed: ____/____ /____

WHAT TYPE OF BREAST CANCER WAS THIS?

- ☐ Not Applicable
- ☐ Invasive Ductal
- ☐ Unknown
- ☐ Invasive Lobular
- ☐ LCIS
- ☐ DCIS
- ☐ NOS
- ☐ Other

WHAT SIDE WAS THE CANCER LOCATED ON?

____Not Applicable ____Unknown ____ Left _____ Right

WHAT TREATMENTS HAVE YOU HAD? (check all that apply)

____Chemotherapy ____Hormone therapy ____Radiation therapy _____ Surgery

HAVE YOU EVER BEEN DIAGNOSED WITH **ANY** OTHER TYPE OF CANCER?

____Yes ____No ____Unknown

IF YES, WHAT TYPE?

Type of Cancer	Yes	No	Unknown
Bladder/Kidney			
Invasive Cervical			
Colorectal			
Leukemia/Lymphoma			
Lung			
Melanoma			
Mouth/Throat			
Ovarian			
Uterine			
Thyroid			
Other			

WHAT TREATMENTS HAVE YOU HAD FOR THIS **PRIOR** CANCER? (please choose below)

___Chemotherapy ___Hormone therapy ___Radiation therapy _____Surgery

HAVE YOU BEEN PREVIOUSLY DIAGNOSED WITH, OR TREATED FOR **ANY** OF THE FOLLOWING?

Disease	Yes	No	Unknown
Myocardial infarction			
Congestive heart failure			
Hypertension			
Peripheral vascular disease			
Dementia			
Diabetes (on meds/insulin)			
Chronic obstructive pulmonary disease			
Peptic ulcer disease			
Moderate or severe renal disease			
Liver disease			
Metastatic cancer			
Cardiac Dysrhythmia			
Throid Disorder			
High Cholesterol			
Asthma			
Arthritis			
Pacemaker in place			
Mitral valve disorder			
Anxiety			
Other illness (specify below)			
Leukemia or polycythemia vera			
Lymphoma			

REVIEWED BY MEDICAL ASSISTANT: _____

DATE: ___/___/___