



# BREAST CARE PROGRAM PRE-BIOPSY INTAKE FORM

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Ht: \_\_\_\_\_ Wt: \_\_\_\_\_

Name: \_\_\_\_\_

Gender: \_\_\_\_\_ F \_\_\_\_\_ M

Last First MI

Ethnicity (check all that apply):  Caucasian  African American  Spanish/Hispanic  
 American Indian/Aleutian/Eskimo  Asian/Pacific Islander  Other \_\_\_\_\_

Address: \_\_\_\_\_

Street City State Zip Code

Daytime Phone: ( ) \_\_\_\_\_  Work  Home  Message can be left

Evening Phone: ( ) \_\_\_\_\_  Work  Home  Message can be left

Authorized Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Email Address: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Gynecologist: \_\_\_\_\_

Do you have any known allergies to the following:  No Known Allergies

- Codeine  Iodine  NSAIDS  Cephalosporins  Latex  
 Aspirin  Morphine  Penicillin  Tylenol  Sulfa  Other: \_\_\_\_\_

Do you have any of the following medical conditions:

- Diabetes Mellitus  Osteoarthritis  Joint Replacement  
 Hypertension  COPD  Artificial Heart Valve  
 Cardiovascular Disease  Oxygen Dependent  Anxiety/Depression  
 Pulmonary Embolus  Lupus erythematosus  Cancer Type: \_\_\_\_\_  
 Rheumatoid Arthritis  Scleroderma Year diagnosed: \_\_\_\_\_  
 Hyperthyroidism  Hypothyroidism  Other: \_\_\_\_\_

Have you been or are you currently a cigarette smoker:  Yes  No

If yes, how long have you been a smoker? Age started: \_\_\_\_\_ Age stopped: \_\_\_\_\_ Ongoing:   
How many packs per day? \_\_\_\_\_ Other tobacco use?  Yes  No What kind? \_\_\_\_\_

Do you use alcohol?  Yes  No Amount per day: \_\_\_\_\_ per week: \_\_\_\_\_ per month: \_\_\_\_\_ per year: \_\_\_\_\_

Age of first menstrual cycle: \_\_\_\_\_ Date of last period: \_\_\_\_\_

Have you experienced menopause?  Yes  No Age at menopause: \_\_\_\_\_

Type:  Natural  Surgical  Drug related

Were your ovaries removed at the time of surgery?  Yes  No

Are you currently pregnant?  Yes  No Are you currently breastfeeding?  Yes  No

How many pregnancies have you had? \_\_\_\_\_ How many live births have you had? \_\_\_\_\_

How old were you when you first child was born? \_\_\_\_\_

Have you ever taken hormone replacement therapy?  Yes  No

If yes, which? \_\_\_\_\_ Age started: \_\_\_\_\_ Age stopped: \_\_\_\_\_

Have you ever used contraceptive methods?  Yes  No Age started: \_\_\_\_\_ Age stopped: \_\_\_\_\_

Type:  Oral  Patch  Depo Provera Shot  Other Type: \_\_\_\_\_

**Have you had a previous breast biopsy?**  Yes  No  Unknown

If yes, what was the date? \_\_\_\_\_ Were there atypical cells found?  Yes  No  Unknown

**Have you had prior breast cancer?**  Yes  No Year diagnosed: \_\_\_\_\_

If yes, did you have a  Right  Left  Bilateral (both sides)  Lumpectomy  Mastectomy

If yes, did you have reconstruction?  Yes  No

If yes, what type of reconstruction?  TRAM:  Pedicle  Free

Latissimus Flap

Implants:  Saline  Silicone

If yes, did you have axillary surgery?  Yes  No What year? \_\_\_\_\_

What side:  Right  Left What type:  Complete axillary lymph node dissection

Sentinel lymph node biopsy

If yes, did you receive radiation therapy?  Yes  No

If yes, did you receive chemotherapy?  Yes  No

If yes, did you receive hormone therapy?  Yes  No

**Have you had a breast reduction?**  Yes  No What year? \_\_\_\_\_

**Have you had a breast augmentation?**  Yes  No What year? \_\_\_\_\_ What type?

Retroglanular (behind breast tissue)  Subpectoral (behind muscle) Substance?  Saline  Silicone

**Have you had prior ovarian cancer?**  Yes  No What year? \_\_\_\_\_

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#### FAMILY HISTORY:

**Do you have a family history of breast cancer?**  Yes  No  Unknown

If yes, which family member(s) ? \_\_\_\_\_ Age of Diagnosis: \_\_\_\_\_

\_\_\_\_\_ Age of Diagnosis: \_\_\_\_\_

\_\_\_\_\_ Age of Diagnosis: \_\_\_\_\_

**Which side of the family?**

Mother **or**  Father

Mother **or**  Father

Mother **or**  Father

**Do you have a family history of ovarian cancer?**  Yes  No  Unknown

If yes, which family member(s) ? \_\_\_\_\_ Age of Diagnosis: \_\_\_\_\_

\_\_\_\_\_ Age of Diagnosis: \_\_\_\_\_

**Which side of the family?**

Mother **or**  Father

Mother **or**  Father

**Do you have a family history of other cancers?**  Yes  No  Unknown

**If yes, which type of cancer and which family member(s)?**

If yes, which family member(s) ?

Type: \_\_\_\_\_ Family Member: \_\_\_\_\_ Age of Diagnosis: \_\_\_\_\_

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Mother **or**  Father

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Mother **or**  Father

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**Are you currently taking any of the following pertinent medications?**  Aspirin  Plavix  Coumadin

Vitamin E  Lovenox  Other blood thinning medication(s)? \_\_\_\_\_

Anti-Depressant - If so, which medication? \_\_\_\_\_ Other? \_\_\_\_\_

**Have you had prior chest radiation?**  Yes  No

If yes, age radiation treatment was received: \_\_\_\_\_ For what indication: \_\_\_\_\_

**Have you been tested for any genetic abnormalities?**  Yes  No

If yes, please indicate the test and results?  BRCA1  Positive  BRCA 2  Positive **Other:** \_\_\_\_\_  Positive

Negative  Negative

Negative

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**My signature is verification that I have read this document and have answered truthfully to the best of my knowledge.**

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**Please do not write below this line: FOR STAFF USE ONLY FACILITY:** \_\_\_\_\_