

BREAST QUESTIONNAIRE

Today's date _____

Your age _____

Current problem/concern: Lump Abnormal imaging Pain Nipple discharge 2nd opinion Other _____

Which breast: Left Right Both Does it vary with menses? Yes No How? _____

When noticed? _____ By whom? _____ Do you do SBE Yes No How often? _____

Have you had a biopsy for this? _____ Result? _____

Has it changed? Yes No How? _____

Have you had other breast problems? Yes No

What? _____ Was biopsy done? Yes No

What side? _____ When? _____

Where? _____ Results _____

Have you had breast cancer in the past? Yes No When?

Type _____ Treatment _____

Chemotherapy? Yes No Radiation? Yes No

When and where were your last three mammograms? _____

GYN History

Age when you started menstrual periods _____

pregnancies _____ # deliveries _____ # miscarriages _____ # abortions _____

Age at first pregnancy _____ Age at first live birth _____ Breast fed? Yes No How many? _____ How long? _____

Do you still have periods? Yes No Start date last menses _____

Date of last PAP _____ Any history of abnormal PAP? Yes No

Current birth control method _____

Ever take birth control pills? Yes No When/how long? _____

Ever take fertility drugs? Yes No What/when/how long? _____

Have you reached menopause? Yes No

Age at menopause? _____ Natural Surgical Chemo induced

Ovaries removed: both one Hysterectomy - reasons for _____

Ever take Hormone replacement / Estrogen/Progesterone? Yes No What/when/how long?

Have you ever taken anti-estrogens? Yes No

Tamoxifen Arimidex Others _____

When/how long/why? _____

Notes: _____

Patient Label

SWEDISH CANCER INSTITUTE

MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ Your cell phone # _____ Date _____

Your physicians who should receive reports:

Name _____ Address _____

Name _____ Address _____

Type of work you do _____

Race / Ethnicity _____ Preferred language _____

Marital status (S M W D P) Name of partner/spouse _____

Height _____ Weight _____

Current medical conditions (For example, diabetes, high blood pressure, taking blood thinners, etc.)

Past Surgeries (Procedure, reason for surgery, date)

Bleeding problems? Yes No Problems with anesthesia? Yes No Claustrophobic Yes No

Allergies to medications? _____ Latex? Yes No

Health Habits

Tobacco use? Never Past Current #Packs / day _____ # of years _____ When quit? _____

Alcohol use? None Social #Drinks / day _____ Ever have a problem with alcohol? Yes No

Recreational Drugs? None Yes What? _____

Ever have a problem with drugs or medication addictions? Yes No Which? _____

Caffeine? Cups per day: Coffee _____ Tea _____ Colas _____ Chocolate _____

Exercise? Regular Occasional Light Moderate Vigorous

Type _____

Recreation / Interests _____

Religion _____

Family History

Family history of cancer No Yes (if yes – complete the attached Family history questionnaire)

Family history of Hypertension Bleeding Heart problems Stroke Diabetes Problems with anesthesia

Review of Systems (✓ or circle symptoms that you currently have or have had in the past year, and explain)

General: Fever, chills, weight gain or loss, night sweats, fatigue, etc. _____

Eyes: Glaucoma, glasses or contact lens, blurred vision, eye injury, etc. _____

HEENT: Hearing loss, earaches, mouth sores, swollen glands in neck, sinus problems, etc. _____

Heart/vessels: Heart attack, chest pain, palpitations, murmur, leg swelling, pacemaker, etc. _____

Lungs: Chronic cough, difficulty breathing, asthma, TB, etc. _____

GI: Loss of appetite, nausea, vomiting, hepatitis, diarrhea, heartburn, etc. _____

GU: Frequent urination, kidney stones, blood in urine, dribbling, etc. _____

Muscles/bones: Joint pain, swelling, stiffness, back pain, artificial joints, etc. _____

Skin: Rash, itching, skin cancer, varicose veins, lupus, etc. _____

Neurological: Headaches, dizziness, seizures, stroke, memory loss, etc. _____

Psychiatric: Depression, nervousness, insomnia, etc. _____

Endocrine: Diabetes, thyroid, etc. _____

Blood/lymph: Clots, HIV, bleeding problems, phlebitis, etc. _____

GYN: Irregular periods, bleeding problems, infertility, etc. _____

Other: _____

Family History Screening Questionnaire

Are you adopted? Yes ___ No ___

Please list all of the blood relatives in your immediate family who have had any form of cancer (mother, father, sister, brother, son, daughter):

<i>Relationship to You</i>	<i>Type of Cancer (e.g., breast, uterus, colon, etc.)</i>	<i>Approximate Age at Diagnosis</i>

Please list all of the blood relatives on both sides of your extended family who have had any form of cancer (aunt, uncle, cousin, niece, nephew, grandparent):

Your Mother's Side Of The Family

<i>Relationship to You</i>	<i>Type of Cancer (e.g., breast, uterus, colon, etc.)</i>	<i>Approximate Age at Diagnosis</i>

Your Father's Side of the Family

<i>Relationship to You</i>	<i>Type of Cancer (e.g., breast, uterus, colon, etc.)</i>	<i>Approximate Age at Diagnosis</i>

Are you Ashkenazi Jewish? Yes ___ No ___

Your Mother's Ancestry (e.g., Italian, Cambodian, Swedish, etc.)

Your Father's Ancestry _____

Patient Label
