CHEROKEE

BREAST CARE

Patient Name: _____
Date of Birth: _____/_____/_____
Present Age: _____ Race: _____
Are you an Ashkenazi? ☐ YES ☐ NO

MEDICAL HISTORY

Chief Complaint *(briefly tell us why you are here today)*: _____

_____

Who referred you to our office? _____

Who is your Primary Care Physician or Family Doctor? _____

When was your last Mammogram? _____ Where was it completed? _____

Please list all chronic and past medical problems (i.e. *autoimmune disease, hypertension, asthma, breast cancer, hyperlipidemia, DCIS, etc.*): _____

_____

_____

Please list all previous surgeries or breast procedures *(i.e. biopsies, mammograms, augmentation, etc.)*: _____

_____

_____

Please list all medications and the dosage for each [**NOTE:** This includes prescriptions (i.e. *blood thinners, etc.)* and over-the-counter (i.e. *aspirin, supplements, etc.*) medications]: _____

_____

Please list any allergies or sensitivities to medications and associated reactions: _____

_____

Have you had any prior allergic reactions to: ◯ Tape ◯ Surgical Glue ◯ Steristrips ◯ Latex

Do you have a mutation in either the BRCA1 or BRCA2 gene, or a diagnosis of a genetic syndrome that may be associated with elevated risk of breast cancer? ☐ YES ☐ NO ☐ Not sure ☐ N/A

Have you ever had a breast biopsy? ☐ YES ☐ NO If yes, how many total? _____

Have you had any breast biopsies with atypical hyperplasia? ☐ YES ☐ NO ☐ Not sure ☐ N/A

Please list any conditions common in your family (i.e. *ovarian cancer, breast cx, pancreatic cx, colon cx, etc., and/or diabetes, hypertension, etc.*): _____

_____

_____

REPRODUCTIVE HISTORY

How many pregnancies have you had? ____ Number of live births? ____ Are you pregnant now? ☐ YES ☐ NO

Age at first period: ___ Age at birth of first child: ___ Age at menopause: ___ Last menstrual period? ___

Have you ever breastfed? ☐ YES ☐ NO Are you breastfeeding now? ☐ YES ☐ NO

Have you used hormone replacement therapy? ☐ YES ☐ NO Have you had radiation therapy? ☐ YES ☐ NO

Have you had a hysterectomy? ☐ YES ☐ NO Have you had your ovaries removed? ☐ YES ☐ NO

Have you had an abnormal mammogram? ☐ YES ☐ NO Have you had any breast surgery? ☐ YES ☐ NO

Have you had a flu shot in the past year? ☐ YES ☐ NO If yes, where did you receive it? _____

Have you ever had a pneumonia vaccine? ☐ YES ☐ NO If yes, where did you receive it? _____

REVIEW OF SYSTEMS

Please circle all of the symptoms you are CURRENTLY experiencing:			
Constitutional / General	Decreased appetite	Weight loss	Weight gain
	Fever	Chills	Fatigue
Eyes	Blurred vision	Visual changes	
HENT	Headaches	Lightheadedness	Dental problems
	Dentures	Neck pain	Hearing loss
	Snoring		
Breasts	Nipple discharge	Bloody nipple discharge	Breast lump or mass
	Changes in breast size	Breast pain	Swelling
	Redness	Tenderness	Gland swelling
	Burning nerve pain		
Cardiovascular	Chest pain or pressure	Palpitations	Irregular heart beats
	Blood clots	Limb swelling	Easy bleeding
Respiratory	Shortness of breath	Wheezing	Cough
Integument / Skin	Rash	Itching	Hair growth changes
	Changes to existing skin lesions or moles		
Psychiatric	Anxiety	Depression	Difficulty Sleeping
Neurologic	Seizures	Numbness	Tingling
	Tremors	Amnesia	Memory difficulties
Musculoskeletal	Joint pain	Back Pain	Hip Pain
	Weakness	Arthritis	Difficulty Sleeping
Endocrine	Weight loss	Cold intolerance	Hot flashes
	Excessive thirst	Loss of hair	Night sweats
Heme-Lymph	Easy bleeding	Easy bruising	Lump in armpit/neck

SOCIAL HISTORY

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Current Occupation: _____ Retired: ☐ YES ☐ NO

Do you smoke tobacco? ☐ YES ☐ NO ☐ FORMER SMOKER If YES, how much per day? _____

If you were a former smoker, for how long _____ and at what age did you start _____ and quit _____ smoking?

Do you drink alcohol? ☐ YES ☐ NO If Yes, how many times in the past year did you have four or more drinks in one day? _____

Do you use illicit substances / recreational drugs (i.e. marijuana, cocaine, heroin, etc.): ☐ YES ☐ NO

PERSONAL & FAMILY CANCER HISTORY

Complete the section below. Include **yourself and all 1st (parents, siblings, children), 2nd (grandparents, aunts, uncles, nieces/nephews), and 3rd (1st cousins) degree male and female blood relatives on both your mother's and father's sides.** Specify which relatives were affected with cancer and estimate ages of diagnosis to the best of your ability.

				1st DEGREE	2nd DEGREE		3rd DEGREE	
Circle No or Yes		CANCER HISTORY	You	Parents / Siblings / Children	Relatives on your Mother's side	Relatives on your Father's side	1st Cousins	Age of Diagnosis
No	Yes	Breast Cancer **before** age 50						
No	Yes	3 or more Breast Cancers on one side of family **any** age						
No	Yes	Breast Cancer in both breasts or breast cancer twice in same person **any** age						
No	Yes	Triple Negative Breast Cancer at **age 60 or younger**						
No	Yes	Male Breast cancer **any** age						
No	Yes	Ovarian Cancer **any** age						
No	Yes	Ashkenazi Jewish with a personal or family of Breast or Ovarian Cancer **any** age						

Patient Signature: _____ **Date:** _____