CENTER for SPECIALTY CARE
A NorthBay Affiliate

1860 Pennsylvania Avenue, Suite 200
Fairfield, CA 94533
(707) 646-4180

This form was designed to reduce the duplication of medical histories taken by many of the physicians you may encounter in the course of your breast care. Please complete the following questions using a blue or black pen. Leave questions blank if you are unsure how to answer the question; a medical staff member will be reviewing the form with you before you see the physician. Thank you for taking the time to fill out this form.

Ethnic Origin

❑ Asian American ❑ African American ❑ Caucasian ❑ Hispanic ❑ Ashkenazi Jewish Ancestry
❑ Other ______________________________

Referral Information

Who referred you to our office? ❑ Doctor ❑ Family ❑ Friend ❑ Self ❑ Internet
Please specify the person's name (if applicable): ______________________________

Main Reason for Visit (please check only one)

❑ Abnormal mammogram ❑ Breast Pain ❑ Breast Lump ❑ Other: ____________________

Breast lump, pain, or "other" first found by*:* ❑ Me ❑ Doctor ❑ Mammogram

Are You Currently Having Any of the Following Problems?

1. Lumps in breast: ❑ No ❑ Right ❑ Left ❑ Bilateral Since when? ________
   How did you find the lump? ______________________________
2. Nipple discharge: ❑ No ❑ Right ❑ Left ❑ Bilateral Since when? _______
   Method of detection: ❑ Spontaneous ❑ Expressed
   Color: ❑ Brown ❑ Green ❑ Red ❑ Clear ❑ White ❑ ________
3. Breast tenderness/pain: ❑ No ❑ Right ❑ Left ❑ Bilateral Since when? _______
   My breast pain is: ❑ Continuous ❑ On and Off
4. Breast redness or swelling: ❑ No ❑ Right ❑ Left ❑ Bilateral Since when? _______
5. Prior breast injury: ❑ No ❑ Yes
6. Other complaints: ______________________________
   ____
   ____

Last Name, First______________________________

Med Rec# ____________________PCP____________________

DOB:________________ Age ________________ SC-02 Rev. 10/12

PATIENT ID STICKER

BREAST HEALTH QUESTIONNAIRE

Mammography Information

Have you had a previous mammogram? ❑ No ❑ Yes: Where? ____________ When? ____ / ____ / ______

Date of your first mammogram: ____ / ____ / ______

Do you practice monthly breast self-exams? ❑ No ❑ Yes ❑ Sometimes

Ob/Gyn History

1. Have you had a hysterectomy? ❑ No ❑ Yes: Date of surgery: ____ / ____ / ______
   Have your ovaries been removed? ❑ No ❑ One ❑ Both ❑ Unsure
2. Date of most recent pelvic exam: ____ / ____ / ______
3. Are you pregnant? ❑ Unsure ❑ No ❑ Yes: Due date - ____ / ____ / ______
4. Age at first menstrual cycle: _____
5. Are you still having periods? ❑ No ❑ Yes
6. Beginning date of last menstrual cycle: ____ / ____ / ______
7. Which option best describes you:
   ❑ Have not had menopause yet ❑ Currently undergoing menopause
   ❑ Not sure if I have undergone menopause
   ❑ Already underwent menopause at age ______ *Type of Menopause:*
   ❑ Natural (periods just stopped by themselves)
   ❑ Surgical (ovaries and/or uterus removal)
8. Number of pregnancies: ______ Live-births: ______ Miscarriages/Abortions: ______
9. Age at first birth: ______ Age at last birth: ______
10. Did you ever breast feed? ❑ No ❑ Yes
    Age at first breast feeding: ______ How long (All the children together) ? ________ months

Hormonal Medical History

1. Birth control pills: ❑ Never used ❑ On and Off use ❑ One long continuous period of use
   Age started: ______ Total years used: ______ Currently taking birth control pills? ❑ No ❑Yes
2. Hormone replacement therapy: ❑ Never used ❑ On and Off use ❑ One long continuous period of use
   Age started: ______ Total years used: ______ Are you currently taking hormones? ❑ No ❑ Yes
3. Infertility drugs/hormones: ❑ Never used ❑ On and Off use ❑One long continuous period of use
   Age started: ______ Age stopped: ______ Total months used: ______

Breast Surgery/Treatment History

1. Have you ever had a breast cyst(s)? ❑ No ❑ Right ❑ Left ❑ Both
   (Cysts are little sacs of fluid that are sometimes drained with a needle or may be seen on a mammogram or ultrasound.)

2. Number of needle biopsies you have had: ❑ None ❑ Right ______ ❑Left ______
   (Needle biopsies are done in the office or in the breast imaging area.)
   Type of needle biopsy: ❑ FNA ❑ Core ❑ Unsure

3. Number of surgical biopsies you have had: ❑ None ❑ Right ______ ❑ Left ______
   (These involve cutting into your skin and are usually done in the operating room.)
   Did the pathology show ADH (atypical ductal hyperplasia)?: ❑ No ❑ Yes ❑Unsure
   Did the pathology show LCIS (lobular carcinoma in situ)?: ❑ No ❑ Yes ❑ Unsure
   Age when first diagnosed with LCIS: ______

4. Have you ever been diagnosed with breast cancer? ❑ No ❑ Right ❑ Left ❑ Both
   If yes, what type of surgery have you had for breast cancer? ❑ Removal of part of the breast
   ❑ Removal of the whole breast
   Did you have reconstruction of the breast? ❑ No ❑ Yes

5. Have you ever had breast implants? ❑ No ❑ Yes: If yes, do you currently have implants? ❑ No ❑ Yes
   Have you ever had silicone implants? ❑ No ❑ Yes
   Any trouble with leaking implants? ❑ No ❑ Yes

Your Health History

1. Height: ______ feet ______ inches Weight: ______ pounds
2. Do you have a history of cancer other than breast cancer? ❑ No ❑ Yes
3. Have you ever had radiation therapy? ❑ No ❑ Yes
4. Have you ever had chemotherapy? ❑ No ❑ Yes
5. Do you have rheumatoid arthritis, lupus, Raynaud's or scleroderma? ❑ No ❑ Yes
6. Have you ever tested positive for AIDS or HIV? ❑ No ❑ Yes
7. Have you ever had general anesthesia? ❑ No ❑ Yes ❑ Unsure
   If yes, were there any problems? ❑ No ❑ Yes
   Do you have any family history of anesthesia problems? ❑ No ❑ Yes
8. Do you have any bleeding problems? ❑ No ❑ Yes
   Are you taking any blood thinners? ❑ No ❑ Yes
   Are you on daily aspirin? ❑ No ❑ Yes
9. Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widow
10. Highest level of education: ❑ High School ❑ Some College ❑ College Degree
11. Current employment status: ❑ Employed ❑ Retired ❑ Disabled ❑ Unemployed
    Occupation: ______________________________
    Occupational toxin exposure history: ______________________________
12. Caffeine (Regular use): ❑ coffee: ______ cups per day / week / month (circle one)
    ❑ NONE ❑ tea: ______ cups per day / week / month (circle one)
    ❑ soda: ______ cans per day / week / month (circle one)
    ❑ chocolate bar: ______ # per day / week / month (circle one)

13. Alcohol use: ❑ No ❑ Yes ❑ Occasionally (Less than 1 drink per week)
If yes, how many drinks per week? _______ Beer: _______ Wine: _______ Hard liquor: _______

14. Tobacco use (ever): ❑ No ❑ Yes ❑ Sporadic use
If yes, type: ❑ Cigarette ❑ Cigar ❑ Pipe ❑ Snuff ❑ Previous smoker
For cigarette smokers: _______ packs/day for _______ years

15. Have you ever taken street/recreational drugs? ❑ No ❑ Yes: specify - ________________________

Current medications and doses: ____

____

____

Drug or food allergies and reactions: ____

____

____

List all previous surgeries and dates: ____

____

____

List any medical problems and when they were diagnosed: ____

____

____

Family History

Please list all relatives including yourself, sons, daughters, mother, father, sisters, brothers, maternal and paternal aunts and uncles, and grandparents. Please include any major medical problems and, if they were diagnosed with cancer, ther age at that time. Circle "Living" or "Deceased" and note the current age, or age at death. If you are adopted, only include your family members that are genetically related to you.

Relationship	Living or Deceased	Age	Major Medical Problems	Type of Cancer(s) & Age at Diagnosis
Daughter / Son	Living Deceased			
Daughter / Son	Living Deceased			
Daughter / Son	Living Deceased			

Mother	Living Deceased			
Father	Living Deceased			
Sibling	Living Deceased			
Sibling	Living Deceased			
Maternal Grandmother	Living Deceased			
Maternal Grandfather	Living Deceased			
Maternal Aunt / Uncle	Living Deceased			
Maternal Aunt / Uncle	Living Deceased			
Paternal Grandmother	Living Deceased			
Paternal Grandfather	Living Deceased			
Paternal Aunt / Uncle	Living Deceased			
Paternal Aunt / Uncle	Living Deceased			

(If additional space is needed, please write on back of this page in same format.)

I have fully reviewed the questionnaire and answered all questions truthfully and to the best of my knowledge. I am aware that my answers could affect my health care, or that of the patient for whom I am responsible:

____ ______/ ______/ __________

Patient Signature Date

____

Relationship *(if signature of parent or guardian)*

I have read and reviewed these results with the patient or responsible party.

____ ______/ ______/ __________

Physician's Signature Date

REVIEW OF SYMPTOMS

Please review and check the appropriate box for any problems you may have now, or had in the past.

General
___Unable to exercise
___Weight Loss
___Planned Weight Loss
___Weight Gain
___No recent weight gain/loss
___Radiation Tx
___Cancer Chemotherapy

Constitutional
___Fever
___Night Sweats
___Loss of Appetite

Infection
___Recent Cold/Flu
___Tuberculosis

Mouth/Throat
___Dental problems
___Mouth Ulcers
___Gum Bleeding/Pain
___Hoarseness
___Difficulty Swallowing

Cardiac
___Heart Attack
___Heart Disease
___High Blood Pressure
___Heart Murmur
___Angina
___Irregular Heart Beats
___Short of Breath
___Palpations
___Mitral Valve Prolapse
___Heart Failure
___Tachycardia
___Pericardial Effusion
___Pacemaker
___Aneurysm
___Leg/Food Edema
___Premature Ventricular Contractions

Respiratory
___Chest Pain
___Asthma
___Chronic Cough
___Pneumonia
___Bronchitis
___Breathing Problems
___Wheezing
___Emphysema
___Short of Breath
___Pleurisy

Gastro-Intestinal
___Stomach Ulcers
___Duodenal Ulcers
___Hepatitis
___Nausea
___Diarrhea
___Blood in Stool
___Heartburn
___Vomiting
___Change in Bowel Habits
___Colitis
___Vomiting Blood
___Intestinal Ulcers
___Liver Problems
___Jaundice
___Hiatal Hernia
___Hemorrhoids
___Constipation
___Irritable Bowel Syndrome

Genito-Urinary
___Kidney Problems
___Nephritis
___Kidney Stone
___Blood in Urine
___Hot Flashes
___Frequent Urination
___Vaginal Discharge
___UTI
___Incontinence of Urine/Stool
___Vaginal Spotting
___Sexual Problems
___Burning on Urination

Hematological/Lymphatic
___Bleeding Tendency
___Hemophilia
___Easy Bruising
___Anemia
___Lymphoma
___Blood Transfusion
Leukemia
___
___Blood Clots
___Red Cell Problems
___Platelet Problems
___Anticoagulants
___Enlarged Lymph Nodes

Endocrine
___Thyroid Problems
___Steroid Use
___Intolerance to Heat/Cold
___Diabetes
___Diabetes (Gestational)

Neurological
___Nerve Injury
___Paralysis
___Headaches
___Stroke
___Seizure
___Migraine Headaches
___Speech Problems
___Balance Problems
___Fainting/Blackouts
___TIA

Rheumatoid
___Rheumatic Fever
___Back Injury
___Neck Injury
___Herniated Disc
___Arthritis
___Rheumatoid Arthritis

Musculoskeletal
___Leg cramps/pain
___Weakness
___Muscle Aches
___Osteoporosis
___Scoliosis

Psychiatric
___Depression
___Mental Problems
___Sleep Problems
___Anxiety

Oro-Gastric
___Esophageal Ulcers

Eyes/Ears/Nose
___Sinus Disease
___Cataracts
___Recent Visual Change
___Nose Bleeds
Double Vision
___
___Ringing in Ears
___Hearing Loss

Skin
___Rashes
___Sores
___Pigmented Moles
___Hives
___Skin Ulcers