PATIENT INFORMATION FORM

Today's date: __ __/__ __/__ __ __ __ (month/day/year)
Date of birth: __ __/__ __/__ __ __ __ (month/day/year)

(Consent)

1. Have you had any of the following breast changes in the last 3 months? *(check all that apply)*

	Both	Left	Right
Lump	☐	☐	☐
Nipple discharge	☐	☐	☐
Pain	☐	☐	☐
Other, describe:_____	☐	☐	☐

☐ No changes

2. When was your last mammogram?
Date: __ __ / __ __ __ __ (month/year)
☐ I never had a mammogram

3. When did a health care provider last examine your breasts?
☐ Never
☐ Within the last 3 months
☐ 4 months to 1 year ago
☐ More than 1 year ago
☐ Not sure

4. Have you ever been diagnosed with breast cancer?
☐ No ☐ Yes
IF YES, please answer the following questions:
Which breast(s)? ☐ Left ☐ Right ☐ Both
At what age were you first diagnosed? __ __ years old
OR: Date of diagnosis: __ __ / __ __ __ __ (month/year)

5. Have you had any of the following breast procedures? *(check all that apply)*

	Left	Right	Both
Fine needle or cyst aspiration	☐	☐	☐
Biopsy	☐	☐	☐
Lumpectomy (for breast cancer)	☐	☐	☐
Mastectomy	☐	☐	☐
Radiation therapy	☐	☐	☐
Breast reconstruction	☐	☐	☐
Breast reduction	☐	☐	☐
Breast implants (still present)	☐	☐	☐

☐ I have not had any of the above procedures

6. Have any blood relatives been diagnosed with breast cancer?

Mother:	☐ No	☐ Yes	☐ Not sure	
Sister:	☐ No	☐ One	☐ 2 or more	☐ Not sure
Daughter:	☐ No	☐ One	☐ 2 or more	☐ Not sure

IF YES, were any diagnosed before age 50?

Mother:	☐ No	☐ Yes	☐ Not sure	
Sister:	☐ No	☐ One	☐ 2 or more	☐ Not sure
Daughter:	☐ No	☐ One	☐ 2 or more	☐ Not sure

7. Have you or a blood relative ever been diagnosed with ovarian cancer?
☐ No
☐ Self
☐ Mother, sister, or daughter
☐ Other relative
☐ Not sure

8. How old were you when you had your first period?
☐ < 12
☐ 12
☐ 13
☐ 14
☐ 15 or older
☐ Not sure
☐ Never started my period

9. Are you **currently** using Hormone Replacement Therapy (HRT) including pills, patches or cream?
☐No ☐Yes

If you are currently using HRT, please check the type:
☐ Estrogen only (such as estradiol, Premarin, Estrace)
☐ Progesterone only (such as medroxyprogesterone acetate, Prometrium, Provera)
☐ Estrogen and Progesterone combination (such as Prempro, Combipatch, Activella, FemHRT)
☐ Do not know the type

How long have you used HRT?
☐ For less than 5 years in a row
☐ Five or more years in a row

Are you **currently** using any of the following:

☐No ☐Yes **Tamoxifen** (also called Nolvadex, Istubal, Valodex)
☐No ☐Yes **Raloxifene** (also called Evista)
☐No ☐Yes **Aromatase Inhibitors**
If you are currently using Aromatase Inhibitors, please check type:
☐ Anastrazole/Arimidex
☐ Letrozole/Femara
☐ Exemestane/Aromasin
☐No ☐Yes **Birth control hormones** (pills, patches, implants)
☐No ☐Yes **Natural hormones for the relief of menopausal symptoms** (such as non prescription herbs like black cohosh and other supplements)

10. Have your menstrual periods stopped permanently? *(check one)*
☐ No
☐ Yes, natural menopause
☐ Yes, but have them now from taking hormones
☐ Yes, surgical procedure
☐ Yes, other reason
☐ Not sure

IF NO or NOT SURE, when was the first day of your last period? __ __/__ __/__ __ __ __ (month/day/year)
IF YES, age at last period: __ __ years old

11. Have you had an ovary removed? (choose one)
☐ No ovary removed
☐ Yes, one ovary removed
☐ Yes, both ovaries
☐ Yes, but don't know if one or both
☐ Not sure

12. Have you given birth?
☐ No ☐ Yes
IF YES: How old were you when your first child was born? __ __ years old

13. What is your current height? __ feet __ __ inches

14. What is your current weight? __ __ __ pounds

15. Are you of Hispanic, Spanish, or Latino origin?

☐ No ☐ Yes

16. What is your racial or ethnic background?

(check all that apply)

☐ White
☐ Black or African American
☐ Asian
☐ Native Hawaiian or other Pacific Islander
☐ American Indian or Alaska Native
☐ Other, describe: _____

17. What is the highest level of education you have completed? *(check one)*

☐ Less than high school graduate
☐ High school graduate or GED
☐ Some college or technical school
☐ College or post-college graduate

18. What kind of healthcare coverage do you have?

(check all that apply)

☐ Medicare ☐ Medicaid ☐ Private insurance
☐ Managed care (such as HMO or PPO)
☐ Other, describe: _____
☐ Not sure
☐ I have no coverage

Thank you for taking time to complete this questionnaire.