



0300004

PLACE LABEL HERE.  
  
IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

**BREAST CARE ADDENDUM**

**General Information:**

Race:  African-American  American Indian  Asian  Caucasian  Hispanic  Pacific Islander  
 Other \_\_\_\_\_

Are you of Ashkenazi Jewish Ancestry?  Yes  No

Gender:  Female  Male

**History of Breast Problem:**

Location of Breast problem: \_\_\_\_\_ Left breast \_\_\_\_\_ Right breast \_\_\_\_\_ Both breasts

Detected by: \_\_\_\_\_ Physician \_\_\_\_\_ Yourself/Patient \_\_\_\_\_ Mammogram

Please indicate your symptoms and which breast is affected:	Left	Right	Not Applicable
Mass/Lump			
Nipple Discharge			
Skin Changes (ex. redness, dimpling)			
Mass/Lump under arm			
Pain			
Abnormal Mammogram			

**Personal Breast History:**

Do you have fibrocystic breasts?  Yes  No Bra Size: \_\_\_\_\_

Have you had breast implants?  Yes ( Silicone  Saline)  No

Do you currently have breast implants?  Yes  No

Have you had a breast biopsy?  Yes  No Number of biopsies: \_\_\_\_\_ Right \_\_\_\_\_ Left

Have you had breast cancer:  Yes  No Side:  Left  Right Age at diagnosis: \_\_\_\_\_

What treatments did you have? (mark all that apply)

Surgery -  Mastectomy  Breast Reconstruction  Lumpectomy  Sentinel lymph node biopsy  
 Axillary lymph node dissection (removal of lymph nodes under arm)

Chemotherapy -  Yes  No # of cycles \_\_\_\_\_ Agents \_\_\_\_\_

Radiation therapy -  Yes  No Hormonal therapy -  Yes  No Type \_\_\_\_\_

Where were you treated for breast cancer? \_\_\_\_\_

Date of most recent mammogram: \_\_\_\_\_ Facility: \_\_\_\_\_

Have you had ovarian cancer:  Yes  No

Have you had genetic testing for the breast cancer gene:  Yes  No Results: \_\_\_\_\_

Do you use complementary/alternative therapies:  Yes  No

If yes, what types: \_\_\_\_\_

Do you have any breast pain?  No  Yes

Rate your breast pain on scale of 1-10 ( 1- no pain, 10 – worst pain of my life ): \_\_\_\_\_



0300004

PLACE LABEL HERE.  
  
IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

**ONCOLOGY BREAST HISTORY ADDENDUM (CONTINUED)**

**Personal Gynecologic History:**

Age at first menstrual period: \_\_\_\_\_ Date of Last Menstrual Period (mm/dd/yy): \_\_\_\_\_

Are you still having periods:  Yes  No

Age when started menopause: \_\_\_\_\_

Have you had a hysterectomy?  Yes  No Date of surgery (mm/dd/yy): \_\_\_\_\_

Have your ovaries been removed?  No  One  Both  Unsure

Are you pregnant now?  No  Yes  Unsure Due date (mm/dd/yy): \_\_\_\_\_

Number of pregnancies: \_\_\_\_\_ Number of live births: \_\_\_\_\_

Number of abortions/miscarriages: \_\_\_\_\_

Age at first live birth: \_\_\_\_\_ Age at last birth: \_\_\_\_\_

Number of children breastfed: \_\_\_\_\_ Age when first nursed: \_\_\_\_\_

Total time nursed all children together (months): \_\_\_\_\_

Have you used birth control pills?  Never  Used on and off in the past  Currently taking

Age first used \_\_\_\_\_ Total years taken \_\_\_\_\_ Date last taken \_\_\_\_\_

Have you used hormone replacement pills?  Never  Used in the past  Currently taking

Age first used \_\_\_\_\_ Total years taken \_\_\_\_\_ Date last taken \_\_\_\_\_

Have you ever used infertility treatments?  No  Yes

Age first used \_\_\_\_\_ Total # cycles \_\_\_\_\_ Date last taken \_\_\_\_\_

How often do you do breast self exams?  Several times monthly  Monthly

Every other month  Rarely  Never

When was your last gynecology exam: \_\_\_\_\_

**Family Cancer History:**

Have any of your relatives ever been diagnosed with breast cancer?  No  Yes

Please list all family members with cancer below (this is a more specific cancer history than on the first page):

Type of Cancer	Relationship to you	Age at Diagnosis	Age of Death/Still living

	Male	Female
How many siblings did your father have?		
How many siblings did your mother have?		
How many siblings do you have?		
How many children do you have?		