NorthShore University HealthSystem – Breast Evaluation Intake Form

Please print this form and complete all questions on each page even if you must answer "Unknown".
Please print clearly.

Today's Date: _____

Name: _____ **Date of Birth**: _____

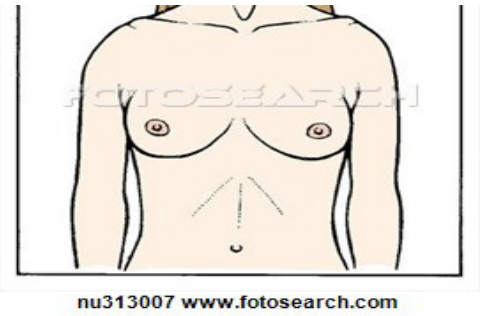
Referring MD: _____ **Other MD**: _____ **Date last physical:** _____

Date of last mammogram:_____ **Date of last breast ultrasound:**_____ **Never:**_____

CURRENT COMPLAINT

Which breast has problem Right _____ Left _____ Both _____

Location of breast complaint (please mark with an **X**): **R** **L**



Duration of Symptoms_____ **None**_____

Presentation: Abnormal Mammogram _____ Lump _____ **Lump found by:** MD _____ Self _____ Other _____

Location of lump: Upper outer _____ Upper inner ____ Lower outer_____ Lower inner_____ Nipple area_____
(if applicable)

Changes (check all that apply): Nipple discharge: Right ____ Left ____ Color of discharge _____

Tenderness ____ Enlarged lymph nodes ____ Skin ____ Nipple ____ **None** ___

Breast self exam practice (BSE): Monthly _____ 2-3 times a year _____ Never _____
(*If you would like to learn BSE, please speak to the Breast Center Nurse*)
Other symptoms: **None** _____ Back pain _____ Chest pain _____ Bone pain _____
Headaches_____ Short of Breath _____ Cough _____ Weight loss _____

Are you currently having pain? Yes _____ No _____

If yes, please describe location and level of pain (scale of 1 -10) _____
_____

MEDICAL / SURGICAL HISTORY

Your age at 1st period _____ **Date last period** _____ **Your age at menopause** _____

Was your menopause natural? Y ____ N ____ Explain: _____

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Number of pregnancies _____ **Number of live births _____** **Did you breast feed?** Y ____ N _____

Your age at 1st live birth _____ **Your age at last birth_____** **Birth control pills:** Y ____ N _____

Hormone replacement therapy: Never ____ Currently _____ Past_____

Date started taking_____ Date stopped taking _____ **Drug Name(s)**:_____

Other hormones: (fertility, regulate periods) Y ____ N _____ **Drug Name(s):_____**

Prior Breast Procedures: Y ___ N ___

Biopsies (which breast, dates) _____

Any diagnosis of atypical hyperplasia: Y ___ N___ Unknown ____

Reduction(s) (date) _____ **Implant(s) (date)** _____

Prior Breast *CANCER* Surgery: **None**____ R(date) _____ L(date) _____
Both(date) _____

Type of surgery: Lumpectomy _____ Modified radical mastectomy ____ Total mastectomy _____
Radical mastectomy ____ Sentinel node biopsy _____ Node dissection _____

Additional treatment:

Chemotherapy (year & drugs used) _____

Radiation (dates) _____

Hormones (year & drugs used) _____

Have you ever **smoked**? Y ____ N ___ How long ? ____ How many packs per day? ____ Quit when? _____

Do you drink **alcohol**? Y ____ N ___How much? _____ Quit when? _____

FAMILY HISTORY

Jewish: Y_____ N_____ **If Yes, Ashkenazi:** Y_____N ____

Ancestry: (i.e. Irish) _____ **Adopted:** Y____ N____

Family history of breast cancer: Y ___ N ___ (specify maternal vs. paternal relative, age at diagnosis):

_____

Family history of other cancers: Y ___ N ___ (specify maternal vs. paternal relative & age at diagnosis):

_____

Concern over family history: Y ____ N ____

OTHER CONCERNS: _____