Fred Hutch
Cancer Center

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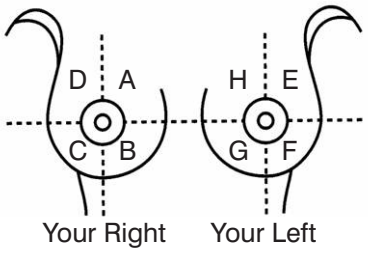
Fred Hutchinson Cancer Center Women's Center

BREAST INTAKE FORM

Name _____ Age _____ Date _____

DOB: _____/_____/_____

WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY?	Use the diagram to the right to answer these questions		
CURRENT BREAST PROBLEM	**Which Side?**	**Which Location by letter?**	**Date Noticed/ Described**
❑ Mass or lump	❑ R ❑ L		
❑ Nipple discharge	❑ R ❑ L		
❑ Skin Changes	❑ R ❑ L		
Redness	❑ R ❑ L		
Orange Peel	❑ R ❑ L		
❑ Abnormal mammogram	❑ R ❑ L		
❑ Breast pain**	❑ R ❑ L		
**Rate your pain: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 No pain Worst pain			
❑ Other	❑ R	❑ L	Date Noticed:



PAST BREAST HISTORY	**Which Side?**	**Date of Diagnosis/Procedure**	**Treatment or Result**
❑ Breast cancer	❑ R ❑ L		
❑ Breast cyst	❑ R ❑ L		
❑ Breast biopsy	❑ R ❑ L		
❑ Other:	❑ R ❑ L		
Do you have breast implants? ❑ Yes ❑ No			

MAMMOGRAM HISTORY
Date of most recent mammogram:
Place where most recent mammogram was done:

OTHER IMAGING HISTORY	**Which Side?**	**Date**
❑ Breast ultrasound	❑ R ❑ L	
❑ Breast MRI	❑ R ❑ L	

TEAM

NAME

PT NO

DOB

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GYNECOLOGICAL HISTORY		
Age when menses (period) began:	Date of last menses:	
Age at first pregnancy:	Number of pregnancies:	Number of full-term deliveries:
My current method of contraception is:		
❑ I currently take oral birth control pills	Age began:	
❑ I previously took oral birth control pills	Age began:	Age discontinued:
❑ I currently take menopausal hormone replacement therapy	Age began:	
❑ I previously took menopausal hormone replacement therapy	Age began:	Age discontinued:

Do you still menstruate?	
❑ **Yes**	❑ **No, I no longer have menstrual periods because of** ❑ **Age _____** ❑ **Natural menopause** ❑ **Hysterectomy** ❑ **Don't know** ❑ **Other:**

FAMILY HISTORY	
(Check box to indicate YES)	**If yes, WHO and AGE at time of diagnosis**
❑ Breast cancer	
❑ Ovarian cancer	
❑ Colon cancer	
❑ Prostate cancer	
❑ Other cancer_____	

Past Medical History: Do you have, or are you being treated for any of the following?		
1. Do you have emphysema, chronic bronchitis, or chronic obstructive lung disease?	❑ **No**	❑ **Yes**
• **If yes, do you take medicine for your condition (either on a regular basis or just for flare-ups)?**	❑ **No**	❑ **Yes**
2. Clotting disorder	❑ No	❑ Yes
3. Heart disease/Heart attack	❑ No	❑ Yes
4. Have you ever been treated for heart failure? (You may have been short of breath and the doctor may have told you that you had fluid in your lungs or that your heart was not pumping)	❑ **No**	❑ **Yes**
5. High Blood Pressure	❑ No	❑ Yes
6. High Cholesterol	❑ No	❑ Yes

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7. Do you have stomach ulcers or peptic ulcer disease?	❑ **No**	❑ **Yes**
a. If yes, was this condition diagnosed by endoscopy (where your doctor looks into your stomach through a scope), or an upper GI or barium swallow study (where you swallow chalky dye and then x-rays are taken)?	❑ **No**	❑ **Yes**
8. Serious liver disease	❑ No	❑ Yes
9. Osteoporosis	❑ No	❑ Yes
10. Skin Disorders	❑ No	❑ Yes
11. Sleeping disorder/trouble sleeping (insomnia)	❑ No	❑ Yes
12. Thyroid Disorder	❑ No	❑ Yes
13. Have you had a stroke, cerebrovascular accident, blood clot, or bleeding in the brain, or transient ischemic attack (TIA)?	❑ **No**	❑ **Yes**
14. Do you have lupus (systemic lupus erythematosus), polymyalgia rheumatic or scleroderma?	❑ **No**	❑ **Yes**
Do you have any of the following conditions:		
15. Alzheimer's Disease or another form of dementia?	❑ **No**	❑ **Yes**
16. Cirrhosis	❑ **No**	❑ **Yes**
17. Have you ever been diagnosed with cancer (excluding breast cancer?)		
a. Type:		
b. If yes, has the cancer spread or metastasized to other parts of your body?	❑ **No**	❑ **Yes**
18. Have you ever had radiation treatment?	❑ **No**	❑ **Yes**
19. Do you have a neurological disorder? (such as: Multiple Sclerosis, Seizures, Parkinson's)	❑ No	❑ Yes
a. If yes, do you take medicine for your condition?	❑ No	❑ Yes
21. Other medical problems (specify)		

SURGICAL HISTORY		
List any surgeries you have had, and when you had them:	**Date (mm/dd/yyyy)**	
Any complications with prior surgery?	❑ **Yes**	❑ **No**
Have you ever had problems with anesthesia?	❑ **Yes**	❑ **No**
A family history of anesthesia problems?	❑ **Yes**	❑ **No**
Have you taken any of the following medications recently?		
Aspirin or Plavix?		
Chemotherapy within the past 30 days?	❑ **Yes**	❑ **No**
Have you ever had Bleomycin or Adriamycin-type chemotherapy?	❑ **Yes**	❑ **No**

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LIFESTYLE	
Occupation:	Marital Status:
Have you ever been exposed to chemicals or radiation? ❑ Yes ❑ No	
Do you smoke tobacco? ❑ Yes ❑ No If yes, how many packs per day?	Age you started smoking:
Have you ever smoked tobacco? For how long?	How many packs per day?
Do you have a personal history of recreational drug use? ❑ Yes ❑ No	
Do you drink alcohol? ❑ Yes ❑ No If yes, how many drinks per week?	
Do you have a personal history of alcoholism? ❑ Yes ❑ No	
How many times per week do you exercise?	
Type of exercise:	Minutes per exercise session:

Current Level of Activity

Which option below best describes your current level of physical functionality WITHIN THE PAST WEEK?

- ❑ **Unknown**
- ❑ **Fully active, able to carry on all usual activities without restriction.**
- ❑ **Restricted in physically strenuous activity, but can walk and is able to carry out light housework.**
- ❑ **Can walk and take care of self, but is unable to carry out any work activities.**
- ❑ **Needs some help taking care of self, spends more then half of day in bed or in a chair.**
- ❑ **Cannot take care of self at all, spends all of my time in bed or chair.**

Completion Status ❑ **No** ❑ **Yes**

Yes *= You have entered all the information you can , even if there are a couple of unknowns*
No *= More information can be added later*

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REVIEW OF SYSTEMS

(CURRENT HEALTH PROBLEMS)

REVIEW OF SYSTEMS *Please review and check "no" or "yes" box*

			Comments – Additional information
General	*Recent Weight gain / loss*	☐ *Yes* ☐ *No*	Current Height: _____ Weight: ___ lbs
	Fatigue / Trouble sleeping	☐ *Yes* ☐ *No*	
	Fever / Chills / Night sweats	☐ *Yes* ☐ *No*	
Ear / Nose / Mouth / Throat	*Hearing Loss / Hearing Aid*	☐ *Yes* ☐ *No*	
	Ear Problems	☐ *Yes* ☐ *No*	
	Nose Problems	☐ *Yes* ☐ *No*	
	Mouth or Throat Problems	☐ *Yes* ☐ *No*	
	Nose bleeds / Sinus Problems	☐ *Yes* ☐ *No*	
	Dental Problems / Dentures	☐ *Yes* ☐ *No*	
	Loose or Missing Tooth / Teeth	☐ *Yes* ☐ *No*	
Eye	*Wear glasses / contacts*	☐ *Yes* ☐ *No*	
	Eye problems	☐ *Yes* ☐ *No*	
	Yellowing of white part of the eyes	☐ *Yes* ☐ *No*	
Neurology	*Problems with vision*	☐ *Yes* ☐ *No*	
	Headaches / Dizziness	☐ *Yes* ☐ *No*	
	Seizures	☐ *Yes* ☐ *No*	
	Fainting / Unconsciousness	☐ *Yes* ☐ *No*	
	Numbness / Tingling / Weakness	☐ *Yes* ☐ *No*	
Heart	*Chest Pain*	☐ *Yes* ☐ *No*	
	Heart Murmur	☐ *Yes* ☐ *No*	
	High Blood Pressure	☐ *Yes* ☐ *No*	
	Recent Heart Attack / MI	☐ *Yes* ☐ *No*	
	Artificial Heart Valve(s)	☐ *Yes* ☐ *No*	
	Able to walk two flights of stairs	☐ *Yes* ☐ *No*	
Lung	*Shortness of breath (day or night)*	☐ *Yes* ☐ *No*	
	Asthma	☐ *Yes* ☐ *No*	
	Sleep Apnea / Snoring	☐ *Yes* ☐ *No*	
	Difficulty sleeping	☐ *Yes* ☐ *No*	
	Lung problems	☐ *Yes* ☐ *No*	
	Recent cold or cough	☐ *Yes* ☐ *No*	
Skin	*Masses / Bumps / Lumps*	☐ *Yes* ☐ *No*	
	Rashes	☐ *Yes* ☐ *No*	
	Lesions/ Cuts /Scrapes	☐ *Yes* ☐ *No*	
	Wounds / Blisters	☐ *Yes* ☐ *No*	

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REVIEW OF SYSTEMS Continued	*Please review and check "no" or "yes" box*		
Any current problems with your health?			**Comments – Additional information**
Stomach / Gastrointestinal/ Colon /Rectum	*Stomach / Abdominal pain* *Hiatal hernia* *Heartburn / Indigestion* *Nausea / Vomiting* *Diarrhea* *Constipation* *Blood in Stool* *Jaundice / Yellowing of skin* *Hepatitis ☐A, ☐B, or ☐C*	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	
Muscles / Bones	*Joint pain (where)* *Back pain /Disc disease* *Sprain / Strain* *Stiffness / Arthritis* *Artificial joint(s)* *Other physical disability*	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	
Urinary Tract	*Urinary Problems* *Pain with urination* *Kidney Problems / Kidney Stones*	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	
Female Issues / Reproduction	*Female Specific Problems* *Could you be pregnant?*	☐ Yes ☐ No ☐ Yes ☐ No	
Blood / Lymph	*Bleeding problems* *Anemia* *Swollen or enlarged glands*	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	
Immunological	*Hay fever* *Allergies* *HIV / Aids*	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	
Endocrine	*Heat / Cold intolerance* *Hyperthyroid / Hypothyroid* *Increased thirst / Diabetes*	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	
Mental Health	*Anxiety / Depression* *Psychiatric Care* *Other Concerns*	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	
Patient Signature: Date:		Provider Signature: Date:	

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NAME [M]

PT NO PLACE EPIC LABEL HERE [F]

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Referring Physician Information

Name: _____ Date of Appointment: _____

If a physician has referred you to the Breast Clinic at the Fred Hutchinson Cancer Center or if there are other physicians currently caring for you, it is important for us to copy them with our recommendations and results of any tests or procedures. Please sign below to acknowledge your consent for sharing this information and then write the names and any contact information you have for these physicians below.

I, the patient or patient's legal representative, hereby grant permission to Fred Hutchinson Cancer Center and UW Medicine to communicate about my/the patient's diagnosis, examination results and recommended treatment planning via telephone, mail, fax, and/or e-mail to the below noted physicians as is professionally deemed necessary or advisable.

Patient's signature (or legal representative): _____

Referring Physician: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone Number: _____

☐ Self – Referred. Check here if you were not referred by a physician,

Other Physicians caring for you:

Physician's name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone Number: _____

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Physician's name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone Number: _____

Physician's name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone Number: _____

Physician's name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone Number: _____

Physician's name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone Number: _____

Physician's name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone Number: _____

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BREAST INTAKE FORM – FEMALE