

| FAMILY HISTORY | |
|---|--|
| (Check box to indicate YES) | If yes, WHO and AGE at time of diagnosis |
| <input type="checkbox"/> Breast cancer | |
| <input type="checkbox"/> Ovarian cancer | |
| <input type="checkbox"/> Colon cancer | |
| <input type="checkbox"/> Prostate cancer | |
| <input type="checkbox"/> 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? • If yes, do you take medicine for your condition (either on a regular basis or just for flare-ups)? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 2. Clotting disorder | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 3. Heart disease/Heart attack | <input type="checkbox"/> No | <input type="checkbox"/> 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) | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 5. High Blood Pressure | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 6. High Cholesterol | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 7. Do you have stomach ulcers or peptic ulcer disease? 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)? | <input type="checkbox"/> No <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> Yes |
| 8. Serious liver disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 9. Osteoporosis | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 10. Skin Disorders | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 11. Sleeping disorder/trouble sleeping (insomnia) | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 12. Thyroid Disorder | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 13. Have you had a stroke, cerebrovascular accident, blood clot, or bleeding in the brain, or transient ischemic attack (TIA)? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 14. Do you have lupus (systemic lupus erythematosus), polymyalgia rheumatic or scleroderma? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Do you have any of the following conditions: | | |
| 15. Alzheimer's Disease or another form of dementia? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 16. Cirrhosis | <input type="checkbox"/> No | <input type="checkbox"/> 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? | <input type="checkbox"/> No <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> Yes |
| 18. Have you ever had radiation treatment? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

TEAM
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| | | |
|---|-----------------------------|------------------------------|
| 19. Do you have a neurological disorder? (such as: Multiple Sclerosis, Seizures, Parkinson's) | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| a. If yes, do you take medicine for your condition? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 21. Other medical problems (specify) | | |
| | | |
| | | |

| SURGICAL HISTORY | |
|--|--------------------------|
| List all 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? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Do you smoke tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many drinks per week? | |
| Do you have a personal history of alcoholism? <input type="checkbox"/> Yes <input type="checkbox"/> 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 than 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

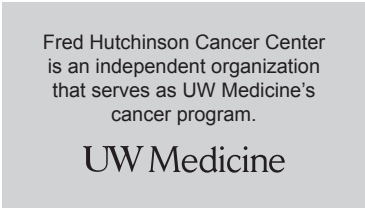
Yes = You have entered all the information you can , even if there are a couple of unknowns

No = More information can be added later

This form needs to be scanned into the medical record. Do not remove from the clinic.

| | |
|-------|-------|
| TEAM | |
| NAME | [M] |
| PT NO | [F] |
| DOB | |

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REVIEW OF SYSTEMS

(CURRENT HEALTH PROBLEMS)

REVIEW OF SYSTEMS

Please review and check "no" or "yes" box

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

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BHC005 (09/22)

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

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BHC005 (09/22)

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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