

**RUSH BREAST SURGEONS PATIENT INTAKE FORM**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why are you here to see the doctor today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Breast Problems:**

1. Do you feel a lump? 🞏 Yes 🞏 No if yes, which side 🞏 R 🞏 L
2. Do you have breast pain? 🞏 Yes 🞏 No if yes, which side 🞏 R 🞏 L
3. Do you have nipple discharge? 🞏 Yes 🞏 No if yes, which side 🞏 R 🞏 L
4. Abnormal Mammogram? 🞏 Yes 🞏 No if yes, which side 🞏 R 🞏 L
5. Have you ever had any previous breast problems? (Examples: surgeries, infections etc.) Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Have you ever had a breast biopsy? 🞏 Yes 🞏 No if yes, Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Risk Analysis:**

1. Do you have any blood relatives with breast or ovarian cancer? 🞏 Yes 🞏 No

2. If you answered yes above, state the relatives relation to you and their age at diagnosis (Example: sister, aunt, mother etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. Are there any other cancer diagnoses in the family? 🞏 Yes 🞏 No

4. Have you been tested for the breast cancer gene? 🞏 Yes 🞏 No

5. Are you of Jewish Ashkenazi descent? 🞏 Yes 🞏 No

6. Age of 1st menstrual period\_\_\_, Last Menstrual period \_\_\_\_, Age at which periods stopped\_\_\_\_\_\_\_\_

7. Age of first Live birth \_\_\_\_\_\_\_\_\_\_\_# of pregnancies\_\_\_\_\_\_\_\_\_\_\_# of children\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Did you breastfeed your children? 🞏 Yes 🞏 No if yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. Have you ever used Birth Control Pills? 🞏 Yes 🞏 No if yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. Have you ever had any fertility treatments? 🞏 Yes 🞏 No if yes, how many and when? \_\_\_\_\_\_\_\_\_\_\_

11. Have you ever used hormone replacement therapy? 🞏 Yes 🞏 No if yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_

12. Have you ever had a Bone Density Scan (also known as Dexa scan/test) 🞏 Yes 🞏 No

If yes, date of last Dexa scan:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIFESTYLE/ENVIRONMENTAL FACTORS/ SOCIAL HABITS**

1. Have you had radiation therapy 🞏 Yes 🞏 No if so, why and how long\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Do you drink of alcohol? 🞏 Yes 🞏 No

If yes, how may drinks do you have in an average week? \_\_\_\_\_\_\_\_\_\_\_

3. Do you smoke? 🞏 Yes 🞏 No 🞏 Former Smoker

If yes, tobacco amount \_\_\_\_\_\_\_ packs/ 🞏day, 🞏Week

If a former smoker, date quit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Highest level of education completed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. What is your marital status? 🞏Single 🞏 Married 🞏 Domestic Partnership 🞏 Widowed 🞏 Divorced

6. With whom do you live? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Medical History: Please list all the major illnesses you have, or have had, the date of diagnosis, and the treatment given (for example: high blood pressure diabetes, heart disease, stroke, etc.)**

**Illness Date Treatment**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PERSONAL SURGICAL HISTORY: Please list all operations, and the dates of operation(s)**

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**MEDICATIONS (PRESCRIPTION)/dose**

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**Over the Counter Medications/Herbal/Dose**

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**ALLERGIES (type of reaction e.g. hives, breathing problems, rash, etc..) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Any other information about your health and well-being that you believe is important and you want your care team to know?**

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**Please check signs and symptoms you are currently experiencing:**

**GENERAL RESPIRATORY GENITOURINARY**

None 🞏 None 🞏 None 🞏

Fever 🞏 Wheezing 🞏 Blood in Urine 🞏

Fatigue 🞏 Cough 🞏 Irregular Menstrual Periods 🞏

Unexplained Weight Loss 🞏 Coughing up Blood 🞏 Abnormal Vaginal Discharge 🞏

Night Sweats 🞏 Shortness of Breath 🞏 Frequent Urination at Night 🞏

Hot Flashes 🞏 Short of Breath Lying Flat 🞏

Sleep Disorder 🞏 Short of Breath on Exertion 🞏

**EYES CARDIOVASCULAR ENDOCRINE**

None 🞏 None 🞏 None 🞏

Blindness 🞏 Irregular Heart Beats 🞏 Heat or Cold intolerance 🞏

Glaucoma 🞏 Fast Heart Rate 🞏 Increased Thirst 🞏

Retinal Problems 🞏 Chest Pain 🞏 Increased Urination 🞏

Wears Glasses or Contacts 🞏 Ankle Swelling 🞏 Excessive Sweating 🞏

**EARS, NOSE, MOUTH & THROAT GASTROINTESTINAL HEMATOLOGIC**

None 🞏 None 🞏 None 🞏

Earaches 🞏 Weight Loss 🞏 Spontaneous Bleeding 🞏

Ringing in the Ears 🞏 Weight Gain 🞏 Transfusion History 🞏

Sinus Problems 🞏 Nausea/Vomiting 🞏 Easy Bleeding or Bruising 🞏

Dental Problems 🞏 Constipated 🞏

Mouth Sores 🞏 Diarrhea 🞏

Sore Throat 🞏

**MUSCULOSKELETAL**  **NEUROLOGICAL PSYCHOLOGICAL:**

None🞏 None 🞏 None 🞏

Joint Pain 🞏 Headache 🞏 Difficult Memory or Concentration 🞏

Muscle Aches 🞏 Weakness 🞏 Sad/Depressed/Tearful 🞏

Numbness 🞏