For Office Use Only: MA complete Date of Visit _____/_____/_____ mm/dd/yyyy

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

UWMC Women's Health Care Center & SCCA Women's Cancer Center

Breast Health Center Patient Intake – Female

Name_____ Age_____ Date_____

Referring Provider:_____ Primary Care Provider (PCP):_____

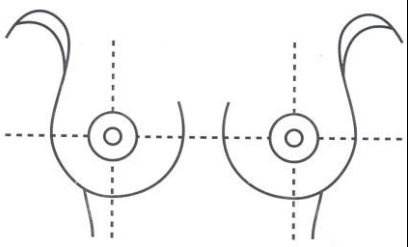
WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY? *EXPLAIN*	

CURRENT BREAST PROBLEM	**Which Side?**	**Date Noticed/Describe**
☐ 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 *(circle)*
No pain Worst pain

☐ No Current Breast Problems

Mark the location(s) of lump or pain on this drawing:



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

PLACE PATIENT LABEL HERE

Breast Health Center Intake – Female

MAMMOGRAM HISTORY	
Age at first mammogram:	Date of most recent mammogram:
Facility where most recent mammogram was done:	

OTHER IMAGING HISTORY	Which Side?	Date
☐ Breast Ultrasound	☐ R ☐ L	
☐ Breast MRI	☐ R ☐ L	
☐ CT	☐ R ☐ L	
☐ Bone Scan	☐ R ☐ L	
☐ PET	☐ R ☐ L	

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:	Years taken:
☐ I currently take hormone therapy	Age began:	Years taken:
☐ I used to take hormone therapy	Age began:	Years taken:

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

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

PLACE PATIENT LABEL HERE

Breast Health Center Intake – Female

Age when menopause occurred:

- ☐ **Not applicable**
- ☐ **Age unknown**
- ☐ **Less than 40**
- ☐ **40 - 44**
- ☐ **45 - 49**
- ☐ **50 - 54**
- ☐ **More than 54**

MEDICATIONS AND ALLERGIES

Please see **PATIENT MEDICATION AND HISTORY** form

PAST MEDICAL HISTORY: Do you have or are you being treated for any of the following?

1.	Allergies	☐ No	☐ Yes
2.	Anxiety/ Depression	☐ No	☐ Yes
3.	**Do you have asthma, emphysema, chronic bronchitis, or chronic obstructive lung disease?**	☐ **No**	☐ **Yes**
	a. If yes, do you take medicine for your condition (either on a regular basis or just for flare ups)?	☐ **No**	☐ **Yes**
4.	Bipolar	☐ No	☐ Yes
5.	Bleeding/Clotting disorder	☐ No	☐ Yes
6.	Chronic muscular/skeletal disorder	☐ No	☐ Yes
7.	Fibromyalgia	☐ No	☐ Yes
8.	Gallbladder	☐ No	☐ Yes
9.	Heartburn/acid reflux	☐ No	☐ Yes
10.	**Have you ever had a heart attack?**	☐ **No**	☐ **Yes**
11.	**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**
12.	Hepatitis: What type?	☐ No	☐ Yes
13.	High blood pressure	☐ No	☐ Yes
14.	High cholesterol	☐ No	☐ Yes
15.	Osteoporosis	☐ No	☐ Yes
16.	Skin disorders	☐ No	☐ Yes
17.	Sleeping disorder/trouble sleeping (insomnia)	☐ No	☐ Yes
18.	Thyroid disorder	☐ No	☐ Yes
19.	**Have you ever had an operation to unclog or bypass arteries in your legs**	☐ **No**	☐ **Yes**

PLACE PATIENT LABEL HERE

Breast Health Center Intake – Female

20. **Have you had a stroke, cerebrovascular accident, blood clot , bleeding in the brain or Transient ischemic attack (TIA)?**	☐ No	☐ Yes
a. **If yes, do you have difficulty moving an arm or leg as a result of a stroke or a cerebrovascular accident?**	☐ No	☐ Yes
21. **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
22. **Do you have diabetes or high blood sugar? If yes,**	☐ No	☐ Yes
a. **is it treated by modifying your diet?**	☐ No	☐ Yes
b. **is it treated by medications taken by mouth?**	☐ No	☐ Yes
c. **is it treated by insulin injections?**	☐ No	☐ Yes
d. **has your diabetes caused problems with your kidneys or problems with your eyes treated by an ophthalmologist?**	☐ No	☐ Yes
23. **Have you ever had problems with your kidneys? If yes,**	☐ No	☐ Yes
a. **Have you had poor kidney function with blood tests showing high creatinine levels?**	☐ No	☐ Yes
b. **Have you used hemodialysis or peritoneal dialysis?**	☐ No	☐ Yes
c. **Have you received a kidney transplant?**	☐ No	☐ Yes
24. **Do you have rheumatoid arthritis?**	☐ No	☐ Yes
a. **If yes, do take medications for it regularly?**	☐ No	☐ Yes
25. **Do you have lupus (systemic lupus erythematosus) or polymyalgia rheumatic?**	☐ No	☐ Yes
Do you have any of the following conditions:		
26. **Alzheimer's Disease or another form of dementia?**	☐ No	☐ Yes
27. **Cirrhosis or serious liver disease?**	☐ No	☐ Yes
28. **AIDS? (This question is optional)**	☐ No	☐ Yes
29. **Leukemia or polycythemia vera?**	☐ No	☐ Yes
30. **Lymphoma?**	☐ No	☐ Yes
31. **Have you ever been diagnosed with cancer (excluding breast cancer)?**	☐ No	☐ Yes
(Other than skin cancer, leukemia or lymphoma)?	☐ No	☐ Yes
If so, what type: ☐ **Unknown**		
32. **If yes, has the cancer spread or metastasized to other parts of your body?**	☐ No	☐ Yes
33. Do you have a neurological disorder? (such as: Multiple Sclerosis, Parkinson's or seizures)	☐ No	☐ Yes
a. If yes, do take medication for your condition?	☐ No	☐ Yes
34. Other (specify):		

PLACE PATIENT LABEL HERE

Breast Health Center Intake – Female

SURGICAL HISTORY	
List any Surgeries you have had and when you had them:	**Date (mm/dd/yyyy)**
List any major illnesses and hospitalizations, and when they occurred:	**Date (mm/dd/yyyy)**

REVIEW OF SYMPTOMS

If you have any of these symptoms, please check "Yes" and circle all that apply

Yes	No	System	Comments
		General (weight gain / loss, fatigue, insomnia, fever / chills)	
		Eyes (glasses / contacts, cataracts, glaucoma)	
		Ear/Nose/Throat (sinus trouble, hearing loss)	
		Heart (chest pain, high blood pressure, coronary artery disease, irregular heart beat)	
		Lungs (shortness of breath, asthma, lung disease)	
		Stomach (heartburn, nausea, diarrhea, hepatitis)	
		Muscle/Bones (joint pain, muscle pain, arthritis, fractures, sprains)	
		Urinary Tract (painful urination, kidney stones, prostate)	
		Skin (masses, blisters, dermatitis, eczema)	
		Neurologic (seizures, numbness/tingling)	
		Mental Health (depression, anxiety)	
		Endocrine (frequent urination, excessive thirst, diabetes, hypothyroid)	
		Hematological (bleeding/clotting problems, anemia, swollen lymph nodes)	
		Allergic/Immunologic (HIV/AIDS, hay fever, lupus)	

Breast Health Center Intake – Female

LIFESTYLE	
Occupation:	Marital Status:
Have you ever been exposed to industrial chemicals or radiation? ☐ Yes ☐ No	
Do you Smoke? ☐ Yes ☐ No If Yes, how many packs per day?	Year you started smoking:
Have you ever smoked? ☐ Yes ☐ No For how long?	How many packs per day?
Do you have a personal history of recreational drug use? ☐ Yes ☐ No	
Do you have a personal history of alcoholism? ☐ Yes ☐ No	
On average, how many caffeinated beverages such as coffee, soda, or tea do you have per day? ☐ None ☐ 1 or 2 ☐ 3 to 4 ☐ More than 5	
On average, how many servings per day do you have of high-fat foods such as fatty meats, fast food, eggs, whole milk, cheese, ice cream, donuts, cookies, chips, or salad dressing? ☐ None ☐ 1 ☐ 2 ☐ More than 3	
How often do you drink alcohol? ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily, or almost daily	
How many alcoholic drinks do you typically have at one time? ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ More than 4	
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 activity 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 day in bed or a chair.

Completion Status: ☐ **No** ☐ **Yes**

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

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