Radiation Oncology Associates

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Breast Care Intake

Date: _____ Date of Birth: _____ / _____ / _____

Contact Information

Full Name: _____

Phone: _____ Email: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Insurance Company: _____

Primary Doctor: _____

Referring Doctor: _____

Please indicate your Breast Symptoms	Right Breast	Left Breast
Mass or Lump	_____	_____
Nipple Discharge	_____	_____
Skin Changes	_____	_____
Underarm Problem	_____	_____
Breast Pain	_____	_____
Abnormal Mammogram	_____	_____
Abnormal Ultrasound	_____	_____

Your Breast History

How old were you when you: Started getting menstrual periods: _____ Stopped menstruating: _____ Last Menstrual Period: _____

Have you ever been pregnant? Y N How many times? _____ How many children were born? _____

How old were you when your first child was born? _____ Did you breastfeed? Y N

Have you had a hysterectomy? Y N Were your ovaries removed? Y N Unsure

Have you ever received chest radiation (X rays) as treatment? Y N Why? _____

Have you ever used:			What type?	At what ages?
Hormonal birth control?	Y	N	_____	_____
Fertility medications?	Y	N	_____	_____
Hormone replacement?	Y	N	_____	_____
Any other kinds of hormones?	Y	N	_____	_____
Have you had exposure to DES?	Y	N	_____	_____

Does anyone in your family have any history of: (list relative, mother or father's side, age of diagnosis)

Breast Cancer	Y	N	_____
Ovarian Cancer	Y	N	_____
Other Cancer	Y	N	_____

Have you ever had problems with your breasts before? Y N Which side? _____

Have you ever had a breast biopsy? Y N What kind? _____ Which side? _____

What did it show? _____

Do you get regular mammograms? Y N How often? _____ Where? _____

Do you do breast self examination? Y N How often? _____

Do you exercise? Y N What type of exercise? _____ How often? _____