Patient History Questionnaire – SCC Breast Surgical Oncology Today's Date:

Patient Name:	Date of Birth:	Age:
Height: Weight:	Occupation:	
Who is with you today? (Name/Relation):		

HISTORY OF PRESENT ILLNESS:

What is the reason for today's visit? _____

Please circle all that apply:

- I feel a lump in my breast. YES NO
  If yes, which breast? RIGHT LEFT
  Present for how long? _____
  Is the lump painful? YES NO
  Does the lump change size with your periods? YES NO
- I have had a Mammogram or Breast Ultrasound in the past. YES NO
  Where? _____
  When? _____
- I have had an **abnormal** Mammogram or Breast Ultrasound. YES NO
- Other breast problems include: _____
- Have you ever had a Breast MRI? YES NO
- Have you ever had Genetic Testing? YES NO
  If yes, when? _____ Location? _____

PERSONAL BREAST HISTORY:

Have you ever had:

- Breast cancer? YES NO
  If yes, which breast? RIGHT LEFT
  When? _____ How was it treated? _____
- Breast biopsy? YES NO
  If yes, which breast? RIGHT LEFT
  When? _____ What were the results? _____
- Injury to your breast? YES NO
  If yes, which breast? RIGHT LEFT When? _____
- Needle aspiration to remove fluid from a breast cyst? YES NO
  If yes, which breast? RIGHT LEFT When? _____
- Nipple discharge? YES NO
  If yes, which breast? RIGHT LEFT When? _____

HORMONAL HISTORY:

If menstruating, date of your last period (first day of): _____

Have you ever used birth control pills? YES NO If yes, how many years? _____

Your age when your period began? _____ Age when you stopped having periods, if applicable? _____

Have you had a hysterectomy? YES NO If yes, at what age? _____ and what was the reason? _____

Do you still have ovaries? YES NO

Are you pregnant now? YES NO

How many times have you been pregnant? _____ How many children do you have? _____

How old were you when your first child was born? _____

Did you breastfeed your children? YES NO

Have you ever taken Hormone Replacement Therapy? YES NO If yes, when? _____ How long? _____

What is your bra size? _____

Do you perform self-breast exams? YES NO

Are you of Ashkenazi Jewish decent? YES NO

FAMILY HISTORY OF **BREAST** CANCER:

RELATIVES	MOTHER'S OR FATHER'S SIDE	AGE AT DIAGNOSIS	ONE OR BOTH BREASTS	IF LIVING, AGE	IF DECEASED, AGE AT DEATH

FAMILY HISTORY OF ANY **OTHER** CANCERS: (E.g., ovarian, colon, prostate, uterine, lung, etc.)

RELATIVES	MOTHER'S OR FATHER'S SIDE	SITE OF CANCER	AGE AT DIAGNOSIS

PAST AND CURRENT PERSONAL MEDICAL PROBLEMS:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

HOSPITAL ADMISSIONS AND/OR SURGERIES:

Date Illness or Operation

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

PHARMACY (NAME & LOCATION) :_____

CURRENT MEDICATIONS: (Include over the counter and herbals)

Medication	Dose	Frequency	Reason to take

ALLERGIES: REACTION:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

SOCIAL HISTORY:

Marital Status: o Single o Married o Widow o Divorced

Do you exercise: o Yes o No Type of exercise: _____

Times per week: _____

Do you smoke: o Yes o No Number of cigarettes per day: _____

Did you smoke: o Yes o No How many years? _____ What year did you quit?_____

Do you drink alcohol? o Yes o No Number of drinks per week: _____

Do you ever feel that you are physically or emotionally threatened by any person? o Yes o No

Do you have any difficulty performing your normal activities of daily living? o Yes o No

Current pain? o Yes o No Severity Scale (circle one): 1 2 3 4 5 6 7 8 9 10

REVIEW OF SYSTEMS: (check all that apply)

Constitutional: o Unexplained weight loss/gain o Appetite loss o Unexplained fever/chills
o Fatigue o Dizziness o Other _____

Eyes: o Vision problems o Frequent headaches o Other _____

Ears/Nose/Throat: o Hearing problems o Ringing in the ears o Bloody nose
o Other _____

Cardiovascular: o Chest pain o High cholesterol o Swelling
o Loss of consciousness o Pacemaker o Other _____

Gastrointestinal: o Indigestion o Heartburn o Nausea/vomiting
o Abdominal pain o Constipation o Diarrhea
o Bloody stool o Other_____

Genitourinary: o Difficult urination o Frequent urination o Bloody urine
o Discharge o Uterine fibroids o Frequent nighttime urination
o Endometriosis o Ovarian cyst o Other _____

Musculoskeletal: o Painful joints o Back pain o Difficulty performing normal activity
o Other _____

Neurological: o Seizures o Speech problems o Tingling of extremities
o Other _____

Respiratory: o Shortness of breath o Wheezing o Cough
o Other _____

SCC Breast Surgical Oncology
(251) 633-0663
SouthernCancerCenter.com