

Contact Information:

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

Email address: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Type/Name of Health Insurance: \_\_\_\_\_

How would you like to receive information?:

- Email     Regular Mail     Both

Health Care Providers:

Surgical Oncologist (            ): \_\_\_\_\_

Medical Oncologist (            ): \_\_\_\_\_

Radiation Oncologist (            ): \_\_\_\_\_

PCP (            ): \_\_\_\_\_

Other: \_\_\_\_\_

Breast Cancer Site:  Left Breast     Right Breast     Bilateral  
Breast Surgery (Date): \_\_\_\_\_

Lumpectomy     Mastectomy     Reconstruction

Ovarian Surgery:  Yes     No

Chemotherapy:  Yes     No    If yes, what drugs:  
 Before or     After Surgery

Herceptin:                     Yes     No

Clinical Trial:                 Yes     No

Radiation therapy:         Yes     No    Where?: \_\_\_\_\_

Endocrine therapy:         None     Tamoxifen     Arimidex     Femara     Aromasin  
Dates: \_\_\_\_\_

Distant metastases:         Yes     No    Site: \_\_\_\_\_

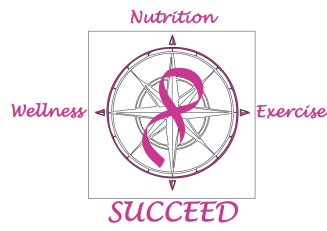
BRCA1/BRCA2 testing:     Yes     No    Result: \_\_\_\_\_

Last Mammogram: \_\_\_\_\_

Last pelvic exam/PAP smear: \_\_\_\_\_

Last Colonoscopy: \_\_\_\_\_

Bone Mineral Density:     Yes     No    Date: \_\_\_\_\_    Result: \_\_\_\_\_



Lymphedema:  Yes  No Treatment:  
 Neuropathy:  Yes  No Treatment:

Still Menstruating:  Yes  No  
 Hot flashes:  Yes  No Treatment:  
 Vaginal Dryness:  Yes  No Treatment:

Depression:  Yes  No  
 Osteoporosis:  Yes  No  
 Obesity:  Yes  No  
 Diabetes:  Yes  No

Heart Disease:  Yes  No  
 High Blood Pressure:  Yes  No  
 High Cholesterol:  Yes  No  
 Thyroid Disease:  Yes  No

Menstrual History:

Age of first menstrual period:  
 First day of last menstrual period:  
 Vaginal bleeding between periods:  Yes  No  
 Oral contraceptives:  Yes  No If yes, which:  
 Hormone replacement therapy:  Yes  No If yes, which:

Reproductive and Sexual History:

Pregnancies: Births:  
 Age at first term pregnancy:  
 Sex drive:  Yes  No  
 Pain during intercourse:  Yes  No  
 Is fertility still desired:  Yes  No

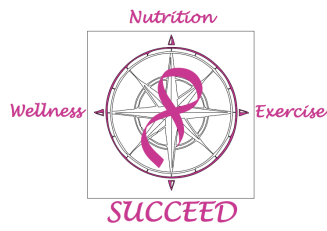
Medications:

Allergies:

General Review:

Fatigue:  Yes  No Difficulty sleeping:  Yes  No Depressed:  Yes  No  
 Anxious:  Yes  No Weight gain/loss:  Yes  No Trouble concentrating:  Yes  No  
 Fevers:  Yes  No Change in Appetite:  Yes  No Night sweats:  Yes  No  
 Pain:  Yes  No Site:

Shortness of Breath:  Yes  No Cough:  Yes  No Wheezing:  Yes  No  
 Trouble swallowing:  Yes  No Pain when swallowing:  Yes  No  
 Reflux symptoms:  Yes  No



Blood in stool:  Yes  No      Change in bowel or bladder habits:  Yes  No  
 Joint stiffness/pain:  Yes  No      Fractures:  Yes  No  
 Muscle weakness:  Yes  No  
 Muscle Pain:  Yes  No

Diet and Exercise:

Fiber  Yes  No      Details:  
 Fruits/Vegetables  Yes  No      Details:  
 Dairy Products  Yes  No      Details:  
 Vitamins  Yes  No      Details:  
 Supplements  Yes  No      Details:  
 Exercise Hours per week \_\_\_\_\_      Details:

Family History/Effectuated family members:

Breast Cancer:  
 Ovarian Cancer:  
 Other cancer:  
 Osteoporosis:  
 Obesity:  
 Diabetes:  
 Heart Disease:

Social History:

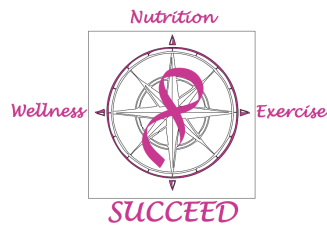
Marital status:  Married  Widowed  Divorced  Single  
 Employment:  Part-time  Full-time  Homemaker  Retired  
 Employment problems after diagnosis:  None  Moderate  Severe (lost job)  
 Do you drink Alcohol?:  Yes  No      how often?:

Do you smoke cigarettes?  Yes  No      If yes, how many packs per day? \_\_\_\_\_ Years? \_\_\_\_\_  
 If no, how many years since your last cigarette?  More than 5 years  Less than 5 years

Other drugs:

Current Concerns:

What brings you to our office today?:



Doctors are aware that emotions play an important part in most illnesses. If your doctor knows about these feelings they will be able to help you more. This questionnaire is designed to help your doctor to know how you feel. Read each item and place a firm tick in the box opposite the reply that comes closest to how you have been feeling **in the PAST WEEK**. Don't take too long over your replies. Your immediate reaction to each item will probably be more accurate than a long, thought-out response.

**1.) I feel tense or 'wound up':**

- Most of the time
- A lot of the time
- Time to time, occasionally
- Not at all

**2.) I still enjoy the things I used to enjoy:**

- Definitely as much
- Not quite as much
- Only a little
- Hardly at all

**3.) I get a frightened feeling as if something awful is about to happen:**

- Very definitely and quite badly
- Yes, but not too badly
- A little, but it doesn't worry me
- Not at all

**4.) I can laugh and see the funny side of things:**

- As much as I always could
- Not quite as much now
- Definitely not as much now
- Not at all

**5.) Worrying thoughts go through my mind:**

- A great deal of the time
- A lot of the time
- From time to time, but not often
- Only occasionally

**6.) I feel cheerful:**

- Not at all
- Not often
- Sometimes
- Most of the time

**7.) I can sit at ease and feel relaxed:**

- Definitely
- Usually
- Not often
- Not at all

**8.) I feel as if I am slowed down:**

- Nearly all the time
- Very often
- Sometimes
- Not at all

**9.) I get a sort of frightened feeling like 'butterflies' in the stomach:**

- Not at all
- Occasionally
- Quite often
- Very often

**10.) I have lost interest in my appearance:**

- Definitely
- I don't take so much care as I should
- I may not take quite as much care
- I take just as much care as ever

**11.) I feel restless as if I have to be on the move:**

- Very much indeed
- Quite a lot
- Not very much
- Not at all

**12.) I look forward with enjoyment to things:**

- As much as I ever did
- Rather less than I used to
- Definitely less than I used to
- Hardly at all

**13.) I can enjoy a good book, radio or TV program:**

- Often
- Sometimes
- Not often
- Very seldom

**14.) I get sudden feelings of panic:**

- Definitely
- Usually
- Not often
- Not at all