



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 (date of last visit):

Medical Oncologist (date of last visit):

Radiation Oncologist (date of last visit):

PCP (date of last visit):

Other:

Breast Cancer

Site: Left breast Right breast Bilateral

Age at diagnosis:

Breast Surgery (date):

Lumpectomy Mastectomy Reconstruction (date)

Prophylactic Ovarian Surgery

Positive Lymph Nodes:

Axillary dissection: Yes No

Sentinel node biopsy: Yes No

Other:

Chemotherapy: Yes No Before or After Surgery

Doxorubicin/Epirubicin: Yes No

Cyclophosphamide: Yes No

Docetaxel/Paclitaxel: Yes No

Herceptin: Yes No

Other Chemotherapy: Yes No Agent:

Clinical Trial: Yes No

Radiation therapy: Yes No

Endocrine therapy: None Tamoxifen Aromatase Inhibitor Other: _____

Ovarian Suppression Dates:

Distant metastases: Yes No Site:

Last Mammogram:

Last pelvic exam/PAP smear:

Bone Mineral Density: Yes No Date: Result:
 Lymphedema: Yes No Treatment:
 Still Menstruating: Yes No
 Hot flashes: Yes No Treatment:
 Vaginal Dryness: Yes No Treatment:
 Neuropathy: Yes No Treatment:

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

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: Yes No Details:

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 Myalgias: Yes No
 Muscle weakness: Yes No Difficulty speaking: Yes No

Family History/Effectuated family members:

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

Social History:

Marital status:
Employment:
Do you smoke?: Yes No how often?:
Do you drink Alcohol?: Yes No how often?:
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

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

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

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

- Definitely
- Usually
- Not often
- Not at all

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

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

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

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

- Often
- Sometimes
- Not often
- Very seldom

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

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

6.) I feel cheerful:

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

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

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

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

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 get sudden feelings of panic:

- Definitely
- Usually
- Not often
- Not at all