M30K1
Rev. 6/11

Duke University Hospital
DUKE UNIVERSITY HEALTH SYSTEM

DUKE MULTIDISCIPLINARY BREAST PROGRAM

Please complete the following questions as accurately as possible. These will help your health care team provide you with the best possible plan of care. If you have questions please see a staff member for assistance.

Name:	Email:
Date of Birth:	Are you registered in the Duke Health View? ☐ Yes ☐ No
Telephone Home: ( )	Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ Partner
Cell: ( )	Race: ☐ Caucasian ☐ Asian, Pacific Islander ☐ African American ☐ American Indian ☐ Aleutian, Eskimo ☐ Other (specify)_____
Work: ( )	
Closest Relative:	Ethnicity: Hispanic ☐ Yes ☐ No
Phone: ( )	

Do you wear glasses/contacts? ☐ Yes ☐ No Do you use a hearing aid? ☐ Yes ☐ No

LANGUAGE(S):

What is your primary language? Write_____ Read _____

What Language(s) do you speak? ☐ English ☐ Spanish ☐ Other _____

How do you learn best? ☐ Written ☐ Listening ☐ Visually ☐ Any of these

EDUCATION:

Highest Grade Level Completed:

IF YOU HAVEN'T BEEN DIAGNOSED WITH BREAST CANCER, please give your employment status at the time you scheduled this appointment.

Occupation: _____

EMPLOYMENT STATUS AT THE TIME OF YOUR DIAGNOSIS WITH BREAST CANCER

Occupation: _____

☐ Employed 32 hours a week or more ☐ Employed less than 32 hours a week ☐ Full-time student
☐ Part-time student ☐ Employed less than 32 hours/wk and part-time student
☐ Homemaker ☐ On medical leave ☐ Disabled, unable to work
☐ Unemployed and/or seeking work ☐ Retired ☐ Other

CURRENT MEDICAL INFORMATION:

Current Physicians

Primary Care Provider: _____

City:_____ Telephone: (_____) _____

Gynecologist Provider: _____

City:_____ Telephone: (_____) _____

Medical Oncologist Provider: _____

City:_____ Telephone: (_____) _____

Radiation Oncologist Provider: _____

City:_____ Telephone: (_____) _____

Have you had a bone density study (for osteoporosis)? ☐ Yes ☐ No If yes, Date _____

Have you had a colonoscopy (to look for colon cancer)? ☐ Yes ☐ No If yes, Date _____

Have you ever had a transfusion of blood or blood products? ☐ Yes ☐ No If yes, Date _____

BREAST RELATED CURRENT COMPLAINT (Why are you here today?): _____

Duration of symptoms: _____

Which breast has a problem? ☐ Rt ☐ Lt ☐ Both Location of breast complaint:_____

☐ Lump ☐ Found by MD ☐ Self Examination ☐ Mammogram

Location of lump (if applicable): ☐ Upper outer ☐ Upper inner ☐ Lower outer ☐ Lower inner ☐ Nipple area

Changes (check all that apply): Nipple discharge ☐ Rt ☐ Lt Color _____

☐ Tenderness ☐ Enlarged Lymph node ☐ Skin ☐ Nipple ☐ None

Date of last mammogram:_____ Where was it done:_____

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BREAST RELATED PAST SURGICAL HISTORY (Include reduction and implants)

DATE	TYPE OF BREAST SURGERY	WHICH BREAST?	WHAT DID THE SURGEON FIND? (Provide benign and atypical hyperplasia)	DOCTOR/HOSPITAL

BREAST RELATED MEDICAL HISTORY

DATE	TYPE OF MEDICAL TREATMENT (to include Chemotherapy)	DOCTOR/HOSPITAL

PAST RADIATION TREATMENT: (please list prior breast radiation first, then other sites)

DATE	SITE OF RADIATION TREATMENT	HOW LONG TREATED?	DOCTOR/HOSPITAL

Menstrual status at the time of diagnosis (or when you scheduled this appointment)
Have you had a period within the past six months?:
☐ **Yes** If YES, please answer questions below. ☐ **No** If NO, please answer questions below. ☐ **NA**

First day of last cycle: _____
Are your periods regular? ☐ Yes ☐ No
Could you possibly be pregnant? ☐ Yes ☐ No
Do you use contraceptives? ☐ Yes ☐ No
If yes, type: _____
If yes, for how long? _____

Why did your periods stop?
☐ Pregnancy
☐ Hysterectomy w/1 or both ovaries left in
☐ Ovaries removed, no hysterectomy
☐ Medical condition associated with ovarian failure
☐ Natural menopause
☐ Hysterectomy: ☐ 1 ovary removed ☐ both ovaries removed
☐ Chemotherapy, radiation, other treatment
☐ Other (please specify) _____
Age at menopause _____ ☐ N/A

How old were you when you started having periods?
Approximate age: _____
Have you ever been pregnant? ☐ Yes ☐ No
If yes: # of pregnancies _____ # of Live births _____
Age at first term pregnancy _____
Did you breastfeed? ☐ Yes ☐ No
Date of last pelvic exam/pap smear: _____
History of abnormal pap-smear? ☐ Yes ☐ No

Have you ever used?
Oral Contraceptives ☐ Yes ☐ No
Intra-Uterine Device (IUD) ☐ Yes ☐ No ☐ Removed ☐ Intact
Fertility drugs ☐ Yes ☐ No If yes, how long? _____
Hormone Replacement Drugs ☐ Yes ☐ No
If yes, how long? _____

Fertility
Many cancer treatments can affect fertility (ability to have children).
Is maintaining your fertility important to you? ☐ Yes ☐ No

There are services available at Duke that may be helpful in some situations to protect fertility.

Would you like to talk with someone about fertility issues? ☐ Yes ☐ No

Sexual Concerns
Would you like to talk with someone about sexual concerns? ☐ Yes ☐ No

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1. Have you ever had a heart attack?	☐ 0=No	☐ 1=Yes
2. 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)	☐ 0=No	☐ 1=Yes
3. Have you ever had a blood clot in your arteries or veins?	☐ 0=No	☐ 1=Yes
a. If yes, have you ever had an operation to unclog or bypass the arteries in your legs?	☐ 0=No	☐ 1=Yes
4. Have you had a stroke, cerebrovascular accident, blood clot or bleeding in the brain, or Transient Ischemia Attack (TIA)?	☐ 0=No	☐ 1=Yes
a. If yes, do you have difficulty moving an arm or leg as a result of a stroke or a cerebrovascular accident?	☐ 0=No	☐ 1=Yes
5. Do you have asthma, emphysema, chronic bronchitis, or chronic obstructive lung disease?	☐ 0=No	☐ 1=Yes
a. If yes, do you take medicine for your condition (either on a regular basis, or just for flare ups)?	☐ 0=No	☐ 1=Yes
6. Do you have stomach ulcers or peptic ulcer disease?	☐ 0=No	☐ 1=Yes
a. If yes, was this condition diagnosed by endoscopy (where a 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)?	☐ 0=No	☐ 1=Yes
7. Do you have diabetes or high blood sugar?	☐ 0=No	☐ 1=Yes
If yes,		
a. Is it treated by modifying your diet?	☐ 0=No	☐ 1=Yes
b. Is it treated by medications taken by mouth?	☐ 0=No	☐ 1=Yes
c. Is it treated by insulin injections?	☐ 0=No	☐ 1=Yes
d. Has your diabetes caused problems with your kidneys or problems with your eyes treated by an opthalmologist?	☐ 0=No	☐ 1=Yes
8. Have you ever had problems with your kidneys?	☐ 0=No	☐ 1=Yes
If yes,		
a. Have you had poor kidney function with blood tests showing high creatinine levels?	☐ 0=No	☐ 1=Yes
b. Have you used hemodialysis or peritoneal dialysis?	☐ 0=No	☐ 1=Yes
c. Have you received a kidney transplant?	☐ 0=No	☐ 1=Yes
9. Do you have rheumatoid arthritis?	☐ 0=No	☐ 1=Yes
a. If yes, do you take medications for it regularly?	☐ 0=No	☐ 1=Yes
10. Do you have lupus (systemic lupus erythematous) or polymyalgia rheumatic?	☐ 0=No	☐ 1=Yes
Do you have any of the following conditions:		
11. Alzheimer's Disease or another form of dementia?	☐ 0=No	☐ 1=Yes
12. Cirrhosis or serious liver disease?	☐ 0=No	☐ 1=Yes
13. AIDS? (This question is optional)	☐ 0=No	☐ 1=Yes
14. Leukemia or polycythemia vera?	☐ 0=No	☐ 1=Yes
15. Lymphoma	☐ 0=No	☐ 1=Yes
16. Cancer (other than skin cancer, leukemia, or lymphoma)?	☐ 0=No	☐ 1=Yes
a. If yes, has the cancer spread or metastasized to other parts of your body?	☐ 0=No	☐ 1=Yes

Past Cancer Experience (excluding breast cancer): ☐ -1=Unknown ☐ 0=No ☐ 1=Yes

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OTHER CONDITIONS: (Continue on separate sheet of paper if needed)

Date	Medical Problem	Treatment	Doctor/Hospital

PAST SURGERY: (Continue on separate sheet of paper if needed)

Date	Type of Surgery	Doctor/Hospital

LIST ALL ADVERSE FOOD AND DRUG REACTIONS: (Include allergy to Soaps and Latex)

Food or Drug	Reaction (Example: Hives)

LIST ALL YOUR MEDICATIONS: (Include all prescription medicine(s), herbal, hormone and over the counter medicines, aspirin, vitamins, inhalers, injections, eyedrops, insulin, etc.) Continue on separate sheet of paper if needed.

Prescription Medicine (Example: Motrin)	Reason for taking Medication	Pill (Example: 200mg)	# of Pills taken @ one time (Example: 1-4)	# of Times Pills taken each day (Example: 4 times a day)

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FAMILY MEDICAL HISTORY: Put N/A in any space that is not applicable.

Relation		Age(s)	Cancer History?	Other Medical Problems?	If Deceased, Age and Cause of Death
# of children					
# of brothers					
# of sisters					
Father					
Father's mother					
Father's father					
# of paternal	Aunts				
	Uncles				
Mother					
Mother's mother					
Mother's father					
# of maternal	Aunts				
	Uncles				

Other relative(s) with cancer and type of cancer:_____

_____

LIFESTYLE:

Do you smoke? ☐ Yes ☐ No If yes: ☐ Cigarette ☐ Pipe ☐ Cigar ☐ Other _____
Have you ever smoked? ☐ Yes ☐ No If yes: # years _____ # packs/day _____
Do you drink alcohol? ☐ Yes ☐ No If yes, how often? ☐ Rarely ☐ Occasionally ☐ Regularly ☐ Daily
Do you exercise regularly? ☐ Yes ☐ No If yes, how often? _____
Do you follow any particular diet? ☐ Yes ☐ No If yes, describe: _____
Have you travelled out of the US in the past three years? ☐ Yes ☐ No
Do you use or have used recreational drugs? ☐ Yes ☐ No If yes, type:_____
How much per day?_____ How many years?_____ If you have quit, when?_____

RELIGIOUS PREFERENCE:

Religious Preference:_____

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PLEASE CHECK ANY SYMPTOMS YOU HAVE HAD IN THE LAST 6 MONTHS:

General:
☐ hot flashes ☐ fever
☐ chills ☐ fatigue
☐ appetite change ☐ weakness/
☐ weight change dizziness
☐ night sweats/change in sleeping pattern

Skin:
☐ rash ☐ color change
☐ texture change ☐ hair loss/growth
☐ new moles ☐ new lesions

Eyes:
☐ pain ☐ inflammation
☐ double vision ☐ vision change
☐ glaucoma

Ears:
☐ pain ☐ inflammation
☐ hearing change ☐ discharge
☐ ringing

Mouth/Throat:
☐ voice change ☐ hoarseness
☐ cough ☐ coughing up blood
☐ sores in mouth or lips
☐ difficulty swallowing

Nose:
☐ congestion ☐ sinus pain
☐ post nasal drip

Cardiovascular/Pulmonary:
☐ chest pain/discomfort/pressure
☐ swelling in legs ☐ cough
☐ fainting ☐ wheezing
☐ palpitations or heart fluttering
☐ shortness of breath

Gastrointestinal:
☐ pain ☐ trouble swallowing
☐ heartburn ☐ nausea vomiting
☐ constipation ☐ diarrhea
☐ jaundice ☐ bleeding
☐ hemorrhoids

Musculoskeletal:
☐ pain ☐ stiffness
☐ swelling ☐ joint pain

Neurological:
☐ headaches ☐ seizures
☐ paralysis ☐ weakness
☐ tremor ☐ balance problems
☐ memory problems
☐ numbness/tingling

Psychological:
☐ mood swings ☐ depression
☐ anxiety ☐ irritability

Genitourinary:
☐ painful/difficult urination
☐ vaginal discharge ☐ bleeding
☐ infections ☐ kidney stones
☐ frequency of urination
☐ rectal bleeding
☐ decrease in size or force of urine stream
☐ hemorrhoids or irritation
☐ foul smelling urine
☐ blood in urine ☐ incontinence
☐ vaginal dryness
☐ vaginal spotting
☐ pain with intercourse

Endocrine:
☐ heat/cold intolerance
☐ excessive urination
☐ excessive thirst

Hematologic:
☐ easy bruising
☐ unusual bleeding

Lymphatic:
☐ pain ☐ lymphedema
☐ enlarged or swollen lymph glands

Other: _____

ADVANCE DIRECTIVE:
Do you have a current living will? ☐ Yes ☐ No
Do you have an assigned Health Care Power of Attorney? ☐ Yes ☐ No
Do you have a copy available? ☐ Yes ☐ No If yes, please bring a copy on your next visit.

FUNCTIONAL STATUS: Please check the box which best describes your activity level:

☐ Fully Active, able to carry on all pre-disease activities without restriction
☐ Restricted in physically strenuous activity but able to walk, and able to carry out work of light or sedentary nature, i.e. light housework or office work
☐ Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about > 50% of waking hours
☐ Capable of only limited self care, confined to bed or chair > 50% of waking hours
☐ Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair

Do you need to see someone regarding any of the following?
☐ Lodging ☐ Equipment needs (home oxygen, walker, hospital bed, etc.) ☐ Transportation ☐ Medications
☐ Personal matters (coping/stress)

Patient Signature: _____ Date: _____ Time: _____

Health Care Provider Signature: _____ Date: _____ Time: _____