Summit Health

BREAST CARE

BREAST CARE CENTER INTAKE FORM

Name:_____ Today's Date: _____

Date of Birth:_____ Referring Provider: _____

Reason for Visit:

☐ Abnormal findings on breast imaging ☐ Breast Pain ☐ Family history of breast cancer
☐ New diagnosis of Breast Cancer ☐ Breast Lump ☐ Nipple Problem
☐ Personal history of Breast Cancer ☐ Other: _____

Have you had recent breast imaging? *(Mammogram, ultrasound, MRI):*
Date: _____
Location:_____

Have you had any of the prior breast procedures?

☐ Lumpectomy ☐ Mastectomy ☐ Needle Biopsy ☐ Breast Reduction ☐ Breast Augmentation

☐ Other:_____

Medical History:

☐ Diabetes ☐ High Blood Pressure ☐ Use of blood thinners *(ex. aspirin, Plavix)*
☐ High Cholesterol ☐ Heart Disease ☐ Smoker/E-cigarettes

Gynecologic History:

Age of first period* _____ ** IVF*: **YES / NO
Age of first childbirth*_____ **Birth control >5 years*: **YES / NO
Age at menopause* _____ **Hormone replacement therapy >5 years*: **YES / NO

Family History:

Breast Cancer: ☐ First Degree (mother/father/siblings) ☐ Second degree (Aunt/uncle/grandparents)
Ovarian Cancer: ☐ First Degree (mother/sister) ☐ Second degree (Aunt/Grandmother)
Other cancers? (ex: colon, prostate, pancreatic) _____

HAVE YOU RECENTLY EXPERIENCED :		NO	YES				NO	YES
CONST	Weight loss of > 10 lbs				SKIN/ INTEG	New breast lumps		
	Fevers					Breast pain		
EYES	Recent visual changes					Nipple discharge		
CV	Chest pain or pressure					Skin rash		
	Irregular heartbeat				LYMPH/HEME	Swollen glands in neck		
RESP	Chronic cough					Swollen glands in armpits		
	Shortness of breath					Easy bruising		
GI	Abdominal pain				NEURO	Chronic headache		
	Blood in stool					Arm Numbness		
MUSCULO	Chronic pain in a joint				PSYCH	Anxiety		
	Muscle pain					Depression		

Patient Signature: _____ Date:_____
Physician Signature:_____ Date:_____