



## Breast Health Center Intake – Female

<b>MAMMOGRAM HISTORY</b>	
Age at first mammogram:	Date of most recent mammogram:
Facility where most recent mammogram was done:	

OTHER IMAGING HISTORY	Which Side?	Date
<input type="checkbox"/> Breast Ultrasound	<input type="checkbox"/> R <input type="checkbox"/> L	
<input type="checkbox"/> Breast MRI	<input type="checkbox"/> R <input type="checkbox"/> L	
<input type="checkbox"/> CT	<input type="checkbox"/> R <input type="checkbox"/> L	
<input type="checkbox"/> Bone Scan	<input type="checkbox"/> R <input type="checkbox"/> L	
<input type="checkbox"/> PET	<input type="checkbox"/> R <input type="checkbox"/> L	

<b>GYNECOLOGICAL HISTORY</b>		
Age when menses (period) began:	Date of last menses:	
Age at first pregnancy:	Number of pregnancies:	Number of full-term deliveries:
My current method of contraception is:		
<input type="checkbox"/> I currently take oral birth control pills	Age began:	Years taken:
<input type="checkbox"/> I currently take hormone therapy	Age began:	Years taken:
<input type="checkbox"/> I used to take hormone therapy	Age began:	Years taken:

<b>FAMILY HISTORY</b>	
(Check box to indicate YES)	<b>If yes, WHO and their AGE at time of diagnosis</b>
<input type="checkbox"/> Breast cancer	
<input type="checkbox"/> Ovarian cancer	
<input type="checkbox"/> Colon cancer	
<input type="checkbox"/> Prostate cancer	
<input type="checkbox"/> Other cancer:	

<b>Do you still menstruate?</b>	
<input type="checkbox"/> Yes	<input type="checkbox"/> No. If no, I no longer have menstrual periods because of: <ul style="list-style-type: none"> <li><input type="checkbox"/> Natural menopause</li> <li><input type="checkbox"/> Hysterectomy</li> <li><input type="checkbox"/> Don't know</li> <li><input type="checkbox"/> Other: _____</li> </ul>

PLACE PATIENT LABEL HERE

**UW Medicine**  
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**Age when menopause occurred:**

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Not applicable | <input type="checkbox"/> 45 - 49      |
| <input type="checkbox"/> Age unknown    | <input type="checkbox"/> 50 - 54      |
| <input type="checkbox"/> Less than 40   | <input type="checkbox"/> More than 54 |
| <input type="checkbox"/> 40 - 44        |                                       |

**MEDICATIONS AND ALLERGIES**

Please see **PATIENT MEDICATION AND HISTORY** form

**PAST MEDICAL HISTORY: Do you have or are you being treated for any of the following?**

- |  |                             |                              |
|--|-----------------------------|------------------------------|
| 1. Allergies   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 2. Anxiety/ Depression   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 3. <b>Do you have asthma, emphysema, chronic bronchitis, or chronic obstructive lung disease?</b>  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| a. <b>If yes, do you take medicine for your condition (either on a regular basis or just for flare ups)?</b>   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 4. Bipolar   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 5. Bleeding/Clotting disorder  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 6. Chronic muscular/skeletal disorder  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 7. Fibromyalgia  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 8. Gallbladder   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 9. Heartburn/acid reflux   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 10. <b>Have you ever had a heart attack?</b>   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 11. <b>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.)</b> | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 12. Hepatitis: What type?  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 13. High blood pressure  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 14. High cholesterol   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 15. Osteoporosis   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 16. Skin disorders   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 17. Sleeping disorder/trouble sleeping (insomnia)  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 18. Thyroid disorder   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 19. <b>Have you ever had an operation to unclog or bypass arteries in your legs</b>  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

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## Breast Health Center Intake – Female

20. Have you had a stroke, cerebrovascular accident, blood clot , bleeding in the brain or Transient ischemic attack (TIA)? a. If yes, do you have difficulty moving an arm or leg as a result of a stroke or a cerebrovascular accident?	<input type="checkbox"/> No  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> Yes
21. Do you have stomach ulcers or peptic ulcer disease?  a. If yes, was this condition diagnosed by endoscopy (where your 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)?	<input type="checkbox"/> No  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> Yes
22. Do you have diabetes or high blood sugar? If yes, a. is it treated by modifying your diet? b. is it treated by medications taken by mouth? c. is it treated by insulin injections? d. has your diabetes caused problems with your kidneys or problems with your eyes treated by an ophthalmologist?	<input type="checkbox"/> No  <input type="checkbox"/> No  <input type="checkbox"/> No  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> Yes  <input type="checkbox"/> Yes  <input type="checkbox"/> Yes
23. Have you ever had problems with your kidneys? If yes, a. Have you had poor kidney function with blood tests showing high creatinine levels? b. Have you used hemodialysis or peritoneal dialysis? c. Have you received a kidney transplant?	<input type="checkbox"/> No  <input type="checkbox"/> No  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> Yes  <input type="checkbox"/> Yes
24. Do you have rheumatoid arthritis? a. If yes, do take medications for it regularly?	<input type="checkbox"/> No  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> Yes
25. Do you have lupus (systemic lupus erythematosus) or polymyalgia rheumatic?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<b>Do you have any of the following conditions:</b>		
26. Alzheimer’s Disease or another form of dementia?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
27. Cirrhosis or serious liver disease?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
28. AIDS? (This question is optional)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
29. Leukemia or polycythemia vera?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
30. Lymphoma?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
31. Have you ever been diagnosed with cancer (excluding breast cancer)? (Other than skin cancer, leukemia or lymphoma)? If so, what type:	<input type="checkbox"/> No  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> Yes
	<input type="checkbox"/> Unknown	
32. If yes, has the cancer spread or metastasized to other parts of your body?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
33. Do you have a neurological disorder? (such as: Multiple Sclerosis, Parkinson’s or seizures) a. If yes, do take medication for your condition?	<input type="checkbox"/> No  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> Yes
34. Other (specify):		

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## Breast Health Center Intake – Female

<b>SURGICAL HISTORY</b>	
List any Surgeries you have had and when you had them:	<b>Date (mm/dd/yyyy)</b>
List any major illnesses and hospitalizations, and when they occurred:	<b>Date (mm/dd/yyyy)</b>

<b>REVIEW OF SYMPTOMS</b>			
If you have any of these symptoms, please check "Yes" and circle all that apply			
Yes	No	System	Comments
		<b>General</b> (weight gain / loss, fatigue, insomnia, fever / chills)	
		<b>Eyes</b> (glasses / contacts, cataracts, glaucoma)	
		<b>Ear/Nose/Throat</b> (sinus trouble, hearing loss)	
		<b>Heart</b> (chest pain, high blood pressure, coronary artery disease, irregular heart beat)	
		<b>Lungs</b> (shortness of breath, asthma, lung disease)	
		<b>Stomach</b> (heartburn, nausea, diarrhea, hepatitis)	
		<b>Muscle/Bones</b> (joint pain, muscle pain, arthritis, fractures, sprains)	
		<b>Urinary Tract</b> (painful urination, kidney stones, prostate)	
		<b>Skin</b> (masses, blisters, dermatitis, eczema)	
		<b>Neurologic</b> (seizures, numbness/tingling)	
		<b>Mental Health</b> (depression, anxiety)	
		<b>Endocrine</b> (frequent urination, excessive thirst, diabetes, hypothyroid)	
		<b>Hematological</b> (bleeding/clotting problems, anemia, swollen lymph nodes)	
		<b>Allergic/Immunologic</b> (HIV/AIDS, hay fever, lupus)	

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## Breast Health Center Intake – Female

<b>LIFESTYLE</b>	
Occupation:	Marital Status:
Have you ever been exposed to industrial chemicals or radiation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you Smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, how many packs per day?	Year you started smoking:
Have you ever smoked? <input type="checkbox"/> Yes <input type="checkbox"/> No For how long?	How many packs per day?
Do you have a personal history of recreational drug use? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a personal history of alcoholism? <input type="checkbox"/> Yes <input type="checkbox"/> No	
On average, how many caffeinated beverages such as coffee, soda, or tea do you have per day? <input type="checkbox"/> None <input type="checkbox"/> 1 or 2 <input type="checkbox"/> 3 to 4 <input type="checkbox"/> More than 5	
On average, how many servings per day do you have of high-fat foods such as fatty meats, fast food, eggs, whole milk, cheese, ice cream, donuts, cookies, chips, or salad dressing? <input type="checkbox"/> None <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> More than 3	
How often do you drink alcohol? <input type="checkbox"/> Never <input type="checkbox"/> Less than monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Daily, or almost daily	
How many alcoholic drinks do you typically have at one time? <input type="checkbox"/> None <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> More than 4	
How many times per week do you exercise?	
Type of exercise:	Minutes per exercise session:

<p><b>Current Level of Activity</b></p> <p><b>Which option below best describes your current level of physical activity WITHIN THE PAST WEEK?</b></p> <p><input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Fully active, able to carry on all usual activities without restriction.</p> <p><input type="checkbox"/> Restricted in physically strenuous activity but can walk and is able to carry out light housework.</p> <p><input type="checkbox"/> Can walk and take care of self, but is unable to carry out any work activities.</p> <p><input type="checkbox"/> Needs some help taking care of self, spends more than half of day in bed or in a chair.</p> <p><input type="checkbox"/> Cannot take care of self at all, spends all day in bed or a chair.</p>
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<p><b>Completion Status:</b>      <input type="checkbox"/> No      <input type="checkbox"/> Yes</p> <p>Yes = You have entered in all the information you can, even if there are a couple of unknowns. No = More information can be added later.</p>
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**This form must be scanned into the medical record. Do not remove from clinic.**