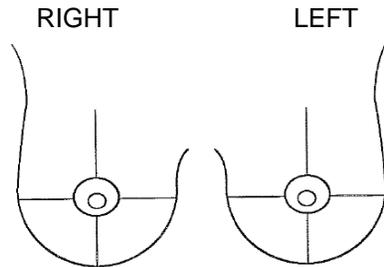


Breast Interview Form

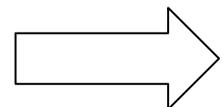
Name: _____

Date: _____

1. Have you had a mammogram for this problem? Yes___ No___
When _____ Where completed _____
2. Have you had a breast ultrasound for this problem? Yes___ No___
When _____ Where completed _____
3. Have you had a biopsy for this problem? Yes___ No___
When _____ Where performed? _____
4. Can you feel the area of concern? Yes___ No___
If yes, please mark on diagram



5. Has the area changed since it was first noted? Yes___ No___
Is it bigger/smaller? Is it more/less noticeable?
What size is it? B-B Pea Grape Walnut
Does it change with your menstrual cycle? Yes___ No___
Describe the change _____
6. Do you have breast pain? Yes___ No___
Mark areas of pain with a "P" on above diagram
Do you take medicine for the breast pain? _____
Does the pain come and go or is it constant? _____
7. Do you have any breast skin changes such as dimpling, redness?
Mark areas of skin changes, on above diagram, with a "S"
8. Do you have nipple discharge? Yes___ No___ Right/ Left/ Both breasts
Color of discharge _____ (such as clear, yellow/green, bloody, rusty, milky)
Does it come out on its own or only when squeezing the breast? _____
9. Have you ever had a breast biopsy or operation? Yes___ No___
Circle the type of procedure: surgical excision of breast lump, needle core biopsy,
lumpectomy for cancer, lymph node sampling for cancer, mastectomy, implants,
reduction/uplift, fine needle biopsy
10. Have you ever had a cyst in your breast? Yes___ No___
Was the cyst drained with a needle or removed surgically? _____



11. Do you have a family history of breast cancer on your **maternal/paternal** side? Yes___ No___
If yes, please **circle the family members with history of cancer**

First degree relatives:

Mother
Father
Sister
Brother
Children

Second degree relatives:

Aunt
Uncle
Niece
Nephew
Grandparents
Grandchildren
Half-siblings

Third degree relatives:

Cousin
Great grandfather
Great grandmother
Great aunt
Great uncle
Great grandchildren

12. Did any of the above people on **either** maternal and/or paternal side have any of the following cancer types:

Breast? Yes/ No Whom and age of diagnosis _____

Ovarian? Yes/ No Whom and age _____

Colorectal? Yes/ No Whom and age _____

20 or more colon/rectal polyps found in 1 person?

Colon/rectal before age 50?

Endometrial/Uterine? Yes/No Whom and age _____

Uterine cancer before age 50?

Prostate? Yes/ No Whom and age _____

Aggressive Prostate cancer (Gleason Score 7 or greater)?

Pancreatic? Yes/ No Whom and age _____

Stomach/Gastric? Yes/ No Whom and age _____

Other: Kidney, Brain, Biliary Tract, Small Bowel, urinary tract cancers? Yes/No
Whom and age _____

13. Has anyone in your family been tested for a genetic gene mutation such as BRCA 1 & 2 or MyRisk Panel? Yes/ No
Whom and would they share their test result form? _____

14. Number of daughters: _____ Number of maternal aunts (mother's sisters): _____
Number of paternal aunts (father's sisters) _____

15. Have you ever had breast cancer? Yes___ No___
Age at diagnosis_____ Did you need radiation? _____
Name of radiation oncologist_____ chemotherapy_____
Name of oncologist_____
- Have you in the past or are you currently taking Tamoxifen, Arimidex, Femera, or other anti-cancer medication? _____

16. Have you ever or are you currently taking:
Estrogen? Name_____ Length of time on estrogen_____
- Progesterone? Yes___ No___
- Birth control pills? Yes___ No___ Length of time on birth control pills_____
- Infertility medications? Yes___ No___ Length of time on medications_____

Office Use Only

- o **Patient meets criteria for genetic discussion**
YES NO

___Breast Cancer at or before age 45
___2 or more separate breast cancers in one person,
one at age 50 or younger
___2 or more breast cancer same side of family, one at
age 50 or younger
___Triple negative breast cancer at age 60 or younger
___3 or more cancers same side at any age:
pancreatic, breast or aggressive prostate
___Pancreatic or aggressive prostate and one relative
with breast at age 50 or younger

- o **Patient appropriate for testing YES NO**

- o **Patient offered testing YES NO**

___Two individuals on the same side of family
with at least 1 with colon/rectal or endometrial
at any age **AND ALSO** 1 diagnosed before
age 50 with Lynch-assoc cancer
___Three or more on same side of family with
Lynch-associated at any age with at least 1
being colon/rectal or endometrial
(Lynch-associated cancers: colon, uterine,
stomach, ovarian, pancreatic, brain, small
bowel, kidney, urinary tract, biliary tract,
sebaceous gland)

- o **Patent Accepted or Declined**

Breast Interview Form

Name: _____

Date: _____