Knoxville Comprehensive Breast Center
KCBC
Screening Diagnosis Treatment

BREAST SURGERY HEALTH INTAKE FORM

Name: _____ Age: ____ Race: _____
Are you of Ashkenazi Jewish heritage?
Yes No

Who referred you to Dr. Duchini's office today? _____
Name of your family doctor: Last _____ First_____
Name of your OB/GYN: Last _____ First_____

Reason for your visit today:
_____
_____

When was your last mammogram? _____
Where was it done? _____
Have you ever had an abnormal mammogram, ultrasound, or MRI of the breast? Yes No

Can you feel, or did your doctor feel, a breast mass? Yes No
If yes, which breast is it in? Right Left Both
How long has it been there? _____
Is it getting larger? _____

Do you have any breast pain? Yes No
If yes, which breast is it in? Right Left Both
Does it get worse around your periods? Yes No
When did it start? _____

Do you have any nipple discharge? Yes No
If yes, which nipple is it from? Right Left Both
How long has it been going on? _____
What color is it? Clear Bloody Green Yellow Milky Brown
Does it come out all by itself or only when you squeeze your nipple? ____ by itself
____ when I squeeze

What is your current Bra & Cup size? _____

How old were you when you began having periods? _____years old

Are you still having periods? Yes No
If yes, when was your last period? _____
If no, how old were you when you went through menopause? _____

Have you ever been pregnant? Yes No
If yes, how many times? _____
How many children do you have? _____
How old were you when you gave birth to your 1st child? _____years old

Have you ever taken birth control pills? Yes No
If yes, how long? _____years
Are you still taking it? Yes No
If no, how long ago did you stop? _____ years

Have you ever taken hormone replacement therapy? Yes No
If yes, how long? _____ years
Are you still taking it? Yes No
If no, how long ago did you stop? _____ years

Did you breast feed? Yes No
If yes, for how long? _____

Did you have a hysterectomy (uterus taken out)? Yes No
If yes, how old were you at the time? _____years old
Why was it removed? _____
Do you still have your ovaries? Yes No

Have you ever had any of the following?
Breast trauma Yes No If yes, which breast was it in? Right Left
Breast Abscess Yes No If yes, which breast was it in? Right Left
Breast Infection Yes No If yes, which breast was it in? Right Left

Have you ever had a breast biopsy? Yes No
If yes, which breast? Right Left Both
When? _____ Where was it done? _____
What was the result? _____

Have you ever had breast surgery? Yes No
If yes, which breast? Right Left Both
What procedure did you have done? _____
When? _____

Have you ever had radiation to your chest? Yes No
i.e.: when you were younger for Hodgkin's Lymphoma

Did you ever have breast cancer? Yes No
If yes, when? _____
Which breast? Right Left
Did you have chemotherapy? Yes No
Did you have radiation? Yes No

Have you ever had any other type of cancer? Yes No
If yes, what type did you have? _____
At what age were you diagnosed? _____

Do you drink caffeinated drinks? (coffee, tea, cola, mountain dew, chocolate)
Yes No If yes, how much? _____

Do you use soy products? Yes No If yes, how much? _____

Do you smoke? Yes No
If yes, how much? _____ For how long? _____
If you used to smoke:
How much? _____ how long? _____ when did you quit?_____

Do you drink alcohol? Yes No
If yes, how much? _____

Have you taken any steroids for more than 2 weeks in the past year? Yes No

Are you taking any herbal over-the-counter medicines? Yes No
If yes list types_____

Any personal or Family history of any reaction to Anesthesia?
If yes, what happened? _____

Any history or high risk of having a blood borne pathogen? Yes No
Ex: Hepatitis B, Hepatitis C, HIV+/AIDS

Do you have any allergies to medications? If yes, list them below:

Medication	what happens when you take it?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you currently taking any medications? If so, list them below: (include any aspirin, herbal, and over the counter products)

Medication	Dose	How often?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any or have had any medical conditions that you are currently being treated for?
Please list all conditions below including heart problems, lung problems, stroke, bleeding problems, etc.

_____
_____
_____
_____
_____
_____
_____

Have you ever had surgery before? If yes, what surgery did you have and when?

Surgery Type	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Marital Status: Single Married Divorced Widowed

Occupation: _____

Did you ever have a reaction to any kind of anesthesia? Yes No
If yes, what kind of anesthesia and what was the reaction? _____

How many children do(did) **YOU** have? Sons _____ Daughters_____

How many siblings do(did) **YOU** have? Brothers_____ Sisters_____

How many siblings does(did) your **FATHER** have? Brothers_____ Sisters_____

How many siblings does(did) your **MOTHER** have? Brothers_____ Sisters_____

1. For **each** relative, fill in their first name, and as much of the requested information as possible
2. Include only blood relatives even if they are no longer living. Please note if they are "half" relatives.
3. For family members who had cancer, the type of cancer & age or year when they were diagnosed is very important.

RELATIVE (**circle one**)	**FIRST NAME**	**CANCER TYPE**	**AGE** at **DIAGNOSIS**	any other **CANCER RELATED** diagnosis	Status- **ALIVE** (age)	Status- **DECEASED** (age at death)
YOU						
CHILDREN						
Daughter / Son						
Daughter / Son						
Daughter / Son						
Daughter / Son						
Daughter / Son						
PARENTS						
Mother						
Father						
SIBLINGS						
Sister / Brother						
Sister / Brother						
Sister / Brother						
Sister / Brother						
Sister / Brother						
PATERNAL RELATIVES (Father's Side)						
Grandmother						
Grandfather						
Aunt / Uncle						
Aunt / Uncle						
Aunt / Uncle						
Aunt / Uncle						
Aunt / Uncle						
MATERNAL RELATIVES (Mother's Side)						
Grandmother						
Grandfather						

Aunt / Uncle						
Aunt / Uncle						
Aunt / Uncle						
Aunt / Uncle						
Aunt / Uncle						

ADDITIONAL INFORMATION

RELATIVE	**FIRST NAME**	**CANCER TYPE**	**AGE** at **DIAGNOSIS**	any other **CANCER RELATED** diagnosis	Status- **ALIVE** (age)	Status- **DECEASED** (age at death)