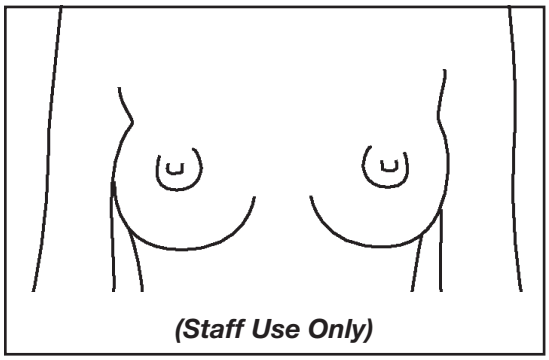
UF Health Breast Center – Medical History Questionnaire

Date: _____/_____/_____

Patient's Last Name	First Name	MI	Age

NAME AND ADDRESS OF PRIMARY CARE OR REFERRING PHYSICIAN:



(Staff Use Only)

Please describe briefly, in your own words, the date of onset of your current problem or illness, any symptoms you have experienced, and the dates of any test and/or treatment(s).

_____

_____

_____

_____

_____

REASON FOR SEEKING CARE

1. Have you been diagnosed with breast cancer recently or are you here to seek treatment for breast cancer?

☐ **Yes** ☐ **No**

2. What was the very FIRST problem that occurred which prompted you to seek medical care? *(Check one)*

☐ abnormal mammogram
☐ lump in breast found by self
☐ lump in breast found by clinician
☐ inverted nipple
☐ bloody discharge from nipple
☐ breast pain or discomfort
☐ lump in breast, don't recall who found it
☐ armpit or axillary mass
☐ other (please specify): _____

At approximately what date did this symptom *(including abnormal mammogram)* become apparent to you?

_____ /_____ /_____

3. Were there any other problems? *(Check all that apply)*

☐ abnormal mammogram
☐ lump in breast found by self
☐ lump in breast found by clinician
☐ inverted nipple
☐ bloody discharge from nipple
☐ breast pain or discomfort
☐ lump in breast, don't recall who found it
☐ armpit or axillary mass
☐ other (please specify): _____

4. When was the date of your last mammogram? _____ /_____ /_____

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Gynecologic History

5. At what age did you have your first period? _____

6. How many times have you been pregnant? _____

7. How many live births have you had? _____

a. If you have children, what was your age at your first full term pregnancy? _____

b. If you have children, what was your age when you had your last full term pregnancy? _____

8. Have you ever breast fed? ☐ **Yes** ☐ **No**

a. If yes, how many months (in total) have you breast fed? _____ months

b. If yes, how many years (or months) ago did you last breast feed? _____ ☐ **Months /** ☐ **Years**

9. Have you had a menstrual period within the last 6 months?

☐ No
☐ Yes, natural menstrual periods or menstrual periods on birth control pills
☐ Yes, menstrual periods on hormone replacement therapy
☐ Unknown

a. If yes, when was your last menstrual period?: _____

b. If no, at what age did you stop having periods?: _____

c. If no, why did you stop having periods? (Check one)

☐ pregnancy and/or breast feeding
☐ natural menopause
☐ hysterectomy with ovaries left in
☐ hysterectomy with both ovaries removed
☐ hysterectomy, unsure about ovaries
☐ both ovaries removed, no hysterectomy
☐ chemotherapy/radiation therapy/hormone therapy
☐ medical condition(s) associated with ovarian failure
☐ hormone replacement therapy (not including HRT for cancer therapy)
☐ other (please specify

10. Have you ever used, or do you currently use, 'post-menopausal' hormone replacement therapy? Do NOT include birth control pills.

☐ No, never
☐ Yes, currently When did you start therapy (month/year)? ! __
☐ Yes, in the past When did you last use hormones (month/year)? __ / __

a. If yes, how many total years (or months) have you used hormone replacement? _____ ☐ **Months /** ☐ **Years**

b. What form(s) of hormones do/did you use? Check ALL that apply.

☐ pill
☐ patch
☐ cream
☐ other _____
☐ estrogen only
☐ progesterone only
☐ combination estrogen and progesterone
☐ do not know

11. Do you use, or have you ever used, birth control pills?

☐ No, never
☐ Yes, currently
☐ Yes, in the past When did you last use birth control pills (month/year)?_____/_____

a. If yes, how many total years (or months) have you used birth control pills? _____ ☐ **Months /** ☐ **Years**

12. Have you ever used fertility drugs? ☐ **Yes** ☐ **No**

a. If yes, have you used Clomiphene citrate (i.e. Serophene, Clomid)? ☐ **Yes** ☐ **No** ☐ **Do not know**
b. If yes, have you used an injectable hormone (i.e. hMG, Gonal-F, Follitism)? ☐ **Yes** ☐ **No** ☐ **Do not know**

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FAMILY HISTORY

Please include only blood relatives, both living and deceased.

13. How many sisters do you have? _____
14. How many brothers? _____
15. How many daughters? _____
16. How many sons? _____
17. Do you have any blood related family relatives who have been diagnosed with cancer or other medical conditions? If yes, please use the chart below to indicate their relationship to you, the type of cancer they have, their age at diagnosis, and their current age if alive or their age at death. Please provide your best estimate for ages.

Blood Relative	Maternal or Paternal	Cancer type	Age at Cancer Diagnosis	Other Medical Conditions	Current Age if Alive	Age at Death if Passed
Example: Mother	*M*	*Breast*	*63*	*High Blood Pressure*	*75*	

SMOKING AND ALCOHOL HISTORY

18. Have you ever or do you currently smoke? *(Check one)*
    - ☐ Yes, but only in the past
    - ☐ Yes, currently
    - ☐ No, never

    a. If yes, at what age did you start smoking? _____
    b. If yes, at what age did you stop smoking? _____

    a. If yes, on average, how many packs per day did you smoke, or do you currently smoke? *(Check one)*
    - ☐ less than ½ pack per day
    - ☐ ½ pack per day
    - ☐ 1 pack per day
    - ☐ 1 ½ pack per day
    - ☐ 2 packs per day
    - ☐ more than 2 packs per day

19. Have you ever or do you currently drink alcohol? *(Check one)*
    - ☐ Yes, but only in the past
    - ☐ Yes, currently
    - ☐ No, never

    a. How many alcoholic beverages *(beer, wine, mixed drinks, etc.)* do you consume weekly? *(Check one)*
    - ☐ none
    - ☐ socially
    - ☐ rarely, less than 1 drink per week
    - ☐ 1-4 drinks per week
    - ☐ 5-9 drinks per week
    - ☐ 10-19 drinks per week
    - ☐ more than 19 drinks per week

PHYSICAL ACTIVITY

20. Which option below best describes your level of physical activity OVER THE PAST WEEK? *(Check one)*
    - ☐ fully active, able to carry on all usual activities without restriction
    - ☐ restricted in strenuous activity; can walk; able to carry out light housework
    - ☐ can walk and take care of self; up more than ½ day
    - ☐ need some help in taking care of self, spend more than ½ day in bed or chair
    - ☐ cannot take care of self at all and spend all my time in bed/chair

PATIENT BACKGROUND INFORMATION

21. Select what best describes your educational status. *(Check one)*
    - ☐ some grade school
    - ☐ some high school
    - ☐ high school graduate
    - ☐ vocational or technical school beyond high school
    - ☐ some college or associate's degree
    - ☐ college graduate
    - ☐ graduate or professional school
    - ☐ other *(please specify)*:

22. What is your current employment status? *(Check one)*
    - ☐ homemaker
    - ☐ employed 32 hours or more per/week
    - ☐ employed less than 32 hours per week
    - ☐ full-time student
    - ☐ part-time student
    - ☐ part-time student, and also employed less than 32 hours per week
    - ☐ on medical leave
    - ☐ disabled
    - ☐ unemployed and/or seeking work
    - ☐ retired
    - ☐ other *(please specify)*:

23. Are you of Spanish/Hispanic Origin? ☐ **Yes** ☐ **No** ☐ **Do not know**

24. Select what best describes your racial background. *(Check one)*

DEFINITIONS FROM FEDERAL GOVERNMENT'S OFFICE OF MANAGEMENT AND BUDGET.

☐ **American Indian or Alaskan Native**	Have origins in any of the original peoples of North and South America (including Central America) and maintain tribal affiliation or community attachment
☐ **Asian**	Have origins in any of the original peoples of the far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam
☐ **Black or African American**	Have origins in any of the original peoples of Africa; includes Haitian
☐ **Native Hawaiian or Other Pacific Islander**	Have origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Island
☐ **White**	Have origins in any of the original peoples of Europe, the Middle East or North Africa

25. Were any of your grandparents of Ashkenazi Jewish descent *(from France, Germany, Eastern Europe or Russia)*?

    ☐ **Yes** ☐ **No** ☐ **Do not know**

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MEDICAL HISTORY

26. Do you currently have, or have you ever had any of the following?

High Blood Pressure?	☐ Yes ☐ No ☐ Do not know
A Heart Attack?	☐ Yes ☐ No ☐ Do not know
High Cholesterol?	☐ Yes ☐ No ☐ Do not know
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 well)*	☐ Yes ☐ No ☐ Do not know
A stroke, cerebrovascular accident (CVA), blood clot or bleeding in the brain or transient ischemic attack (TIA)?	☐ Yes ☐ No ☐ Do not know
If yes, do you have difficulty moving an arm or leg as a result of a stroke or cerebrovascular accident?	☐ Yes ☐ No ☐ Do not know
Asthma, emphysema, chronic bronchitis or chronic obstructive lung disease (COPD) If yes, do you take medicine for your condition (either on a regular basis or just for flare-ups)?	☐ Yes ☐ No ☐ Do not know
Stomach ulcers or peptic ulcer disease (PUD)?	☐ Yes ☐ No ☐ Do not know
a. If yes, is it treated by modifying your diet?	☐ Yes ☐ No ☐ Do not know
b. If yes, is it treated by medications taken by mouth?	☐ Yes ☐ No ☐ Do not know
c. If yes, is it treated by insulin injections?	☐ Yes ☐ No ☐ Do not know
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 have x-rays are taken)?	☐ Yes ☐ No ☐ Do not know
Diabetes or high blood sugar?	☐ Yes ☐ No ☐ Do not know
Problems with your kidneys?	☐ Yes ☐ No ☐ Do not know
Autoimmune Disease such as Rheumatoid arthritis, Lupus, or other form of autoimmune disease?	☐ Yes ☐ No ☐ Do not know
Lupus or polymyalgia rheumatica?	☐ Yes ☐ No ☐ Do not know
Alzheimer's Disease, or another form of dementia?	☐ Yes ☐ No ☐ Do not know
Cirrhosis, or serious liver damage?	☐ Yes ☐ No ☐ Do not know
HIV/AIDS?	☐ Yes ☐ No ☐ Do not know
Other medical conditions not listed *(other than cancer)*? If yes, please list: _____	☐ Yes ☐ No ☐ Do not know

PAST CANCER HISTORY

27. Please list all cancers with which you have been diagnosed, the year you were diagnosed, and the treatment(s) received:

PAST SURGERY/OPERATIONS

28. Please list in chronological order (include type, reason, and approximate year):

TYPE OF SURGERY	HOSPITAL/CITY/STATE	YEAR

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PAST BREAST BIOPSIES

29. How many previous breast biopsies have you had, including any needle core and surgical excisional biopsies?

DO NOT include cyst aspirations or the recent biopsy leading up to your current breast cancer diagnosis.

Please list these biopsies below.

Year	Which Breast (Right or Left)	Needle Core Biopsy or Excisional Biopsy?	Diagnosis (please circle the result of your biopsy)
			Benign Fibroadenoma Atypia (ADH/ALH) LCIS
			Benign Fibroadenoma Atypia (ADH/ALH) LCIS
			Benign Fibroadenoma Atypia (ADH/ALH) LCIS
			Benign Fibroadenoma Atypia (ADH/ALH) LCIS

MEDICATIONS

30. Please list any medications you are now taking (include name, dosage, and frequency):

TYPE OF MEDICATION	DOSAGE	FREQUENCY

ALLERGIES

31. Are you allergic to any medicines? ☐ **Yes** ☐ **No**

if so, please list any medications to which you have had an allergic reaction, and the type of reaction:

b. Are you allergic to latex? ☐ **Yes** ☐ **No**

32. Are you allergic to any foods? ☐ **Yes** ☐ **No**

If so, please list any foods lo which you have had an allergic reaction, and the type of reaction:

REVIEW OF SYSTEMS *(Check all that apply)*

GENERAL:
- ☐ Fever
- ☐ Chills
- ☐ Night sweats
- ☐ Fatigue
- ☐ Generalized weakness
- ☐ Change in appetite (recent)
- ☐ Weight loss

EYES:
- ☐ Wear contacts/glasses
- ☐ Irritation
- ☐ Cataracts
- ☐ Redness
- ☐ Glaucoma
- ☐ Yellowing of the eyes
- ☐ Change in vision
- ☐ Color blindness

EAR/NOSE/THROAT:
- ☐ Hearing loss
- ☐ Nasal congestion
- ☐ Hoarseness
- ☐ Ringing in the ears
- ☐ Nose bleeds
- ☐ Change in voice
- ☐ Ear drainage
- ☐ Snoring
- ☐ Facial trauma
- ☐ Earaches
- ☐ Pain in mouth/throat
- ☐ Color blindness

LUNGS:
- ☐ Cough
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Phlegm
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Coughing up blood
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Pleurisy/Chest Pain
- ☐ Difficulty in breathing with exertion
- ☐ Abnormal sound when breathing

REVIEW OF SYSTEMS *Continued* *(Check all that apply)*

HEART/VASCULAR:

- ☐ Chest pain
- ☐ Fainting or near-fainting
- ☐ Chest pain while walking
- ☐ Chest pressure/ discomfort
- ☐ Difficulty breathing when lying flat
- ☐ Palpitations
- ☐ SOB/Coughing at night
- ☐ Irregular heartbeat
- ☐ Swelling of legs

GASTROINTESTINAL

- ☐ Difficulty or pain with swallowing
- ☐ Constipation
- ☐ Change in bowel habits
- ☐ Reflux symptoms
- ☐ Yellowing of the skin
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Indigestion
- ☐ Abdominal pain
- ☐ Dark or bloody stools
- ☐ Nausea
- ☐ Vomiting blood

GENITOURINARY

- ☐ Frequent urination
- ☐ Urinary incontinence
- ☐ Skin abnormalities on genitals
- ☐ Needing to get up at night to urinate
- ☐ Decreased urine stream
- ☐ Urinary hesitancy or retaining urine
- ☐ Blood in the urine
- ☐ Painful urination
- ☐ Vaginal/Penile discharge

SKIN/HAIR/NAILS:

- ☐ Rash
- ☐ Change in skin color
- ☐ Itching
- ☐ Change in a mole
- ☐ Skin lesions
- ☐ Dry skin

What is your sun exposure history? *(Check all that apply)*

- ☐ I have frequent or long-term sun exposure
- ☐ I have a history of blistering sunburns (particularly during childhood)
- ☐ I have used/currently use a tanning bed

HEMATOLOGIC/ LYMPHATIC:

- ☐ Bruise easily
- ☐ Blood transfusion (Date: ____/____/____)
- ☐ Bleed easily
- ☐ Persistent swollen glands or lymph nodes

HEAD AND NERVOUS SYSTEM:

- ☐ Migraines or severe headaches
- ☐ Trembling/tremors
- ☐ Loss of sensation/ numbness
- ☐ Seizures/Epilepsy
- ☐ Fainting/Black outs
- ☐ Problems walking
- ☐ Speech problems
- ☐ Dizziness
- ☐ Weakness
- ☐ Coordination problems
- ☐ Memory problems
- ☐ Tingling or burning in hands/feet

PSYCHIATRIC/ SOCIAL:

- ☐ Abusive relationship
- ☐ Depression
- ☐ Bipolar
- ☐ Feeling of despair
- ☐ Sleep disturbance
- ☐ Anxiety
- ☐ Other (Describe):

BREAST:

- ☐ Breast lump/mass ☐ L ☐ R ☐ Both
- ☐ Nipple discharge ☐ L ☐ R ☐ Both Color: _____
- ☐ Breast pain/tenderness ☐ L ☐ R ☐ Both
- ☐ Date of last mammogram (Date: ____/____/____)

MUSCULOSKELETAL:

- ☐ Muscle pain
- ☐ Stiff joints
- ☐ Back pain
- ☐ Bone pain
- ☐ Joint pain/swelling
- ☐ Neck pain
- ☐ Muscle weakness

ENDOCRINE:

- ☐ Poor/Slow wound healing
- ☐ Thyroid disease
- ☐ Weight loss/gain
- ☐ Fertility or hormone problems
- ☐ Cold intolerance

ALLERGIC/ IMMUNOLOGIC:

- ☐ Hives
- ☐ Hay fever
- ☐ Angioedema (Rapid throat swelling)
- ☐ Anaphylaxis

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