NATIONAL
BREAST CENTER
David C. Weintritt, MD, FACS
Tammy Smith RN MSN, FNP-C

Name: _____ DOB: _____

Current breast problem or concern:

Symptoms	***Please mark as R (right), L(left), or B (both)***	***When did you first notice it, please explain?***
Pain?		
Lump or mass?		
Changes in the color or texture of the skin on your breast?		
Nipple discharge?		
Nipple inversion?		
Change in the shape or size of the breast?		
Swelling of axillary lymph nodes		

Date of last mammogram? _____ Which facility? _____

Date of last ultrasound? _____ Which facility? _____

Have you had breast problems in the past, Yes or No? _____ If yes, please explain in chart below.

Past Problems/Concerns	***Which breast?***	***Date?***	***Outcome/Treatment?***
Abnormal imaging			
Fine needle aspiration			
Biopsy, core or excisional			

Have you had breast cancer in the past? _____ When? _____

Was your breast cancer invasive? _____ What surgery was performed? _____

Did you receive chemotherapy? _____Did you receive radiation therapy? _____

If you had radiation, was it whole breast or brachytherapy? _____

Have you ever taken anti-hormone therapy (endocrine therapy)?_____ Which medication? _____

When? _____ How long did you take the medication?_____

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Have you ever had genetic testing for breast or ovarian cancer? Result? _____

Has anyone in your family had genetic testing for breast or ovarian cancer? Result? _____

Have you ever taken hormone replacement? _____If yes, over what age span? _____

Family history of cancer:

Are you adopted? _____ Are you of Ashkenazi decent? _____

Please list any first or second-degree relatives that have had ***breast, ovarian, colon, or pancreatic cancer***, and their age at diagnosis:

Relationship to you?	***Mother's or Father's side***	***Type of cancer?***	***Age at diagnosis***

Have you ever been diagnosed with any of the following problems?

- Asthma, COPD Please explain _____
- Kidney disease, Please explain _____
- Thyroid disease, Please explain _____
- Diabetes, Please explain _____
- Hypertension, Please explain _____
- Stroke, Please explain _____
- HIV/AIDS, Please explain _____
- Cancer, Please explain _____

Social History:

Do you currently smoke? _____ How many cigarettes per day? _____ For how many years?_____

Are you a former smoker? _____ How many cigarettes per day? _____ For how many years? _____

Do you use caffeine? _____ What kind and how much? _____

Alcohol Intake? None Occasional Moderate Heavy Illicit drug use? _____

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Past Surgical History: Please check if no prior surgeries ____

List all prior surgeries and the year they were performed

1. _____ Year? _____
2. _____ Year? _____
3. _____ Year? _____
4. _____ Year? _____
5. _____ Year? _____
6. _____ Year? _____

Current Medications: Please check if no current medications ____

1. _____ Dose? _____
2. _____ Dose? _____
3. _____ Dose? _____
4. _____ Dose? _____
5. _____ Dose? _____
6. _____ Dose? _____

Allergies: Please check if no current allergies ____

1. Medication _____Severity?_____ Reaction? _____
2. Medication _____Severity?_____ Reaction? _____
3. Medication _____Severity?_____ Reaction? _____
4. Medication _____Severity?_____ Reaction? _____
5. Medication _____Severity?_____Reaction? _____
6. Other (latex, food) _____ Severity?_____Reaction? _____

Referring Provider:_____

Primary Care Physician: _____

Pharmacy Name: _____

Pharmacy Address:_____

Height:_____ **Weight:**_____