

**UCSF Carol Franc Buck Breast Care Center
Breast Cancer Prevention Program
Supplemental Patient History Intake Form**

Name: _____ Date: _____

Major reasons for clinic visit (please check all that apply):

Breast Health Concerns:

- | | |
|---|---|
| <input type="checkbox"/> Risk of Breast Cancer | <input type="checkbox"/> Surveillance Options |
| <input type="checkbox"/> Current Breast Problem | <input type="checkbox"/> Family History of Cancer |
| <input type="checkbox"/> Prophylactic Surgery | <input type="checkbox"/> Other-please explain |
| <input type="checkbox"/> Chemoprevention | _____ |

Women's Health Concerns:

- | | |
|--|--|
| <input type="checkbox"/> Menopause | <input type="checkbox"/> Nutrition |
| <input type="checkbox"/> Hormone replacement therapy | <input type="checkbox"/> Exercise |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Other- please explain |
| <input type="checkbox"/> Other cancer risk | _____ |

Medical History

- | | |
|--|-----|
| 1) History of migraine headaches? | Y N |
| If yes, related to menstrual cycle of hormones? | Y N |
| 2) Do you currently take synthroid (thyroid replacement)? | Y N |
| 3) Do you have a known low Bone Mineral Density or Osteoporosis? | Y N |
| Have you ever had a bone mineral density test? | Y N |
| If yes, when was your last test and what were the results? | |
| _____ | |
| 4) Have you ever had a deep vein thrombosis (blood clot)? | Y N |
| If yes, was this during pregnancy? | Y N |
| Other reason please explain: _____ | |

5) Are you taking any of the following drugs (please circle all that apply):

- | | | | |
|------------------|-------------------|---------------------|------------------------|
| Tamoxifen | Raloxifene | Fosamax | Bisphosphonates |
| Statins | Niacin | Gemfibrozole | |

Screening/Prevention History

- 6) Date of most recent mammogram? _____
 Results: _____
 Do you receive at least 1 mammogram per calendar year? Y N

- 7) Do you perform monthly breast self-exams (BSE)? Y N
Have you ever been shown how to correctly perform a BSE? Y N

8) Date of last pap/pelvic examination? _____

If you are over age 50 or with a family history of colon cancer:

9) Date of most recent fecal occult blood test? _____

10) Date of most recent colonoscopy or flexible sigmoidoscopy? _____

Lifestyle and Nutrition

11) Do you eat at least 5 servings of fruits/vegetables per day? Y N

12) Do you include beans, nuts, seeds, or soy products into your diet at least several times per week? Y N

13) Do you eat at least 3 whole grains daily? Y N

14) Do you limit/avoid intake of red meat? Y N

15) Do you limit/avoid your intake of pickled, salted, cured, blackened, fried, or barbequed foods? Y N

16) Do you limit your high fat foods intake? Y N

17) Do you prepare a majority of your meals from scratch? Y N

Environmental Issues

18) Chemical exposures during your past or current job? Y N
If yes, please explain: _____

19) Have you had any radiation to the chest wall (not including mammograms), such as for the treatment of Hodgkin's lymphoma? Y N

20) Have you ever been exposed to DES (diethylstilbestrol)? Y N

21) Number of alcoholic drinks per week (average)? _____

22) How did you hear about the Breast Cancer Prevention Program?

- Primary care doctor or OB/GYN
- Radio or Television
- Newspaper or Magazine
- Friend or Family Member
- Other (please explain): _____