

**NEW PATIENT INTAKE FORM**

**PATIENT NAME:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_

**AGE:** \_\_\_\_\_

**PRESENTATION (WHY YOU ARE REQUESTING AN EVALUATION):**

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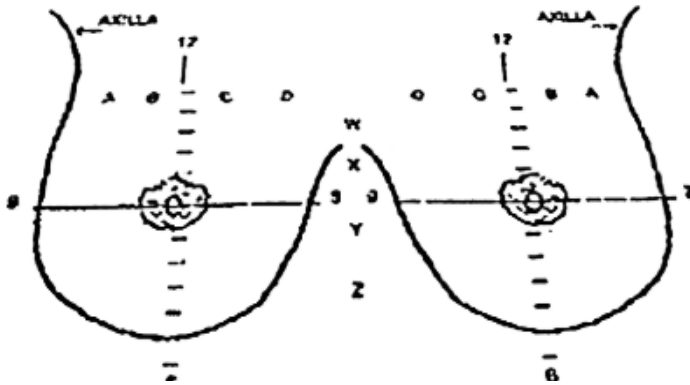


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**BREAST PATIENTS:**  No symptoms  Symptoms as follows:  Right Breast  Left Breast  Both Breasts



**Mass/Lump:**  Painful  Not painful  Came on suddenly  Found on mammogram

**Nipple discharge:**  Bloody  Watery  Milky  Spontaneous (comes out on its own)

**Skin changes of the breast:**  Dimpling (pulling in)  Redness  Scaliness  Skin thickening

**Pain/Soreness:**  Mild  Moderate  Severe  Cyclical (worse before period)  Continuous

**Abnormal mammogram and/or ultrasound; biopsy recommended**

**Abnormal mammogram and/or ultrasound; biopsy performed:** \_\_\_\_\_

**New breast cancer diagnosis**  DCIS

**RISK FACTORS:**

I have a **personal history of cancer** as follows:  N/A  Breast  Ovarian  Uterine  Cervical  
 Pancreatic  Melanoma  Prostate  Colon  Kidney  Bladder  Brain  Thyroid  Stomach  
 Lymphoma  Leukemia  Other cancer(s): \_\_\_\_\_

**Details of personal history of cancer:**

\_\_\_\_\_  
\_\_\_\_\_

**MENSTRUAL/REPRODUCTIVE HISTORY:**

Menarche (Age of first menstrual period): \_\_\_\_\_  First Term Pregnancy (Age at first live birth): \_\_\_\_\_  
 Breastfed: \_\_\_\_\_  # breast biopsies: \_\_\_\_\_  Atypia: \_\_\_\_\_

**IMAGING:**

Approximate date of most recent mammogram (and facility): \_\_\_\_\_  
 Approximate date of most recent MRI if applicable (and facility): \_\_\_\_\_  
 Approximate date of most recent thermogram if applicable (and facility): \_\_\_\_\_  
 Approximate date of most recent ABUS if applicable (and facility): \_\_\_\_\_  
 Other imaging details: \_\_\_\_\_

**FAMILY HISTORY:**

I have a **family history of cancer** as follows:  N/A  Breast  Ovarian  Uterine  Cervical  
 Pancreatic  Melanoma  Prostate  Colon  Kidney  Bladder  Brain  Thyroid  Stomach  
 Lymphoma  Leukemia  Other cancer(s): \_\_\_\_\_

**Details of family history of cancer:** (first name and relationship of affected person with you, age at diagnosis):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I have a known familial genetic mutation in the family as follows:**  BRCA1  BRCA2  CHEK2  ATM

PALB2  MLH1  MSH2  MSH6  PMS2  OTHER MUTATION: \_\_\_\_\_

**I have a known genetic mutation as follows:**  BRCA1  BRCA2  CHEK2  ATM  PALB2  MLH1

MSH2  MSH6  PMS2  OTHER MUTATION: \_\_\_\_\_

**PAST MEDICAL HISTORY:**

**Approximate Height:** \_\_\_\_\_ **Approximate Weight:** \_\_\_\_\_

Heart issues  Atrial fibrillation  blood thinner  
 Lung issues  COPD  Asthma  History of blood clots (DVT/PE)  
 Other: \_\_\_\_\_

**MEDICATIONS (PLEASE LIST NEATLY):**

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**PAST SURGICAL HISTORY:**

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**ALLERGIES (PLEASE LIST NEATLY):**

No Allergies \_\_\_\_\_

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**TOBACCO:**

Never smoker  Former smoker  Current smoker \_\_\_\_\_

**ALCOHOL:** \_\_\_\_\_

**SOCIAL HISTORY:**

Single  Married  Divorced

Work: \_\_\_\_\_  Stay at home

Significant current stressors: \_\_\_\_\_

Other factors to know about me: \_\_\_\_\_

**REVIEW OF SYSTEMS (LIST NEATLY ANY SYMPTOMS):**

**GENERAL:** \_\_\_\_\_

**DENTAL ISSUES:** \_\_\_\_\_

**SKIN:** \_\_\_\_\_

**HEART:** \_\_\_\_\_

**LUNGS:** \_\_\_\_\_

**ABDOMINAL:** \_\_\_\_\_

**NEURO:** \_\_\_\_\_

**CLOTTING/BLEEDING ISSUES:** \_\_\_\_\_