

MERCY WOMEN'S CENTER
4300 McAuley Blvd. Oklahoma City, OK 73120
(405) 936-5455 FAX (405) 936-5217
Alan B. Hollingsworth, M.D.

DATE _____ NAME _____

Date of Birth _____ Age _____ SSN _____

REFERRED BY _____ REPORTS TO _____

REASON FOR BREAST CLINIC VISIT:

Lump found by patient [] Lump found by physician [] Abnormality on mammogram []
 Breast symptoms [] Risk assessment/Genetics [] Other(specify) _____

CURRENT BREAST HISTORY: Do you have the following?

	YES	NO	NOT SURE
BREAST LUMP	[]	[]	[] If YES, for how long? _____
BREAST PAIN	[]	[]	[] If YES, for how long? _____
NIPPLE DISCHARGE	[]	[]	[] If YES, for how long? _____
NIPPLE/SKIN CHANGES	[]	[]	[] If YES, for how long? _____

PAST BREAST HISTORY: Have you even been told that you have the following?

	YES	NO	NOT SURE
FIBROCYSTIC CHANGE	[]	[]	[] If YES, When? _____
BREAST CYSTS	[]	[]	[] If YES, When? _____
FIBROADENOMA	[]	[]	[] If YES, When? _____
MASTITIS	[]	[]	[] If YES, When? _____
BREAST CANCER	[]	[]	[] If YES, When? _____
Other _____			

Have you ever had breast cyst aspiration? [] YES [] NO
 Have you ever had a "needle test" of a solid lump? [] YES [] NO
 Have you ever had a breast biopsy? [] YES [] NO

If YES, give date, location of test, and which breast: _____

Have you ever had mammograms? [] YES [] NO Date of last Mammogram _____

Done where? [] Mercy Women's Center [] Elsewhere: specify _____

PAST MEDICAL HISTORY:

In the past, have you ever been diagnosed with breast cancer? [] YES [] NO
If yes, age of diagnosis _____ one side _____ both sides _____

Have you ever been diagnosed with ovarian cancer? [] YES [] NO
If yes, age of diagnosis _____

Have you been diagnosed as having cancer of any other type? [] YES [] NO
Specify: _____

Have you ever undergone radiation therapy of any type? [] YES [] NO

Do you have any other medical condition the doctor should be aware of?
[] YES [] NO If YES, specify: _____

List previous surgical procedures:	Date
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Other hospitalizations:	
1. _____	_____
2. _____	_____
3. _____	_____

List medications you currently take (both prescribed and over the counter):	
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

List allergies and type of reaction:	
1. _____	reaction: _____
2. _____	reaction: _____
3. _____	reaction: _____

SOCIAL HISTORY:

Occupation _____ Marital Status _____

Number of children _____

Cigarette use [] YES [] NO If yes, how many packs/day? _____ how long _____

Alcohol use [] YES [] NO

If yes, circle one: Infrequently 1-2 drinks/day 3 or more drinks/day

ANCESTRAL HISTORY: Are you of Ashkenazi Jewish heritage? [] YES [] NO

FAMILY HISTORY:

Have any of your relatives had breast cancer? YES NO

If YES, please list:

For grandparents, aunts,
and cousins, please note
"maternal" (mothers' side)
or "paternal" (fathers' side)

1) Relation _____
Age at Diagnosis _____
 In one breast In both breasts
Current Status Deceased, due to breast cancer
 Deceased, due to other causes
 Living, with persistent cancer
 Living, free of known cancer

2) Relation _____
Age at Diagnosis _____
 In one breast In both breasts
Current Status Deceased, due to breast cancer
 Deceased, due to other causes
 Living, with persistent cancer
 Living, free of known cancer

3) Relation _____
Age at Diagnosis _____
 In one breast In both breasts
Current Status Deceased, due to breast cancer
 Deceased, due to other causes
 Living, with persistent cancer
 Living, free of known cancer

4) Relation _____
Age at Diagnosis _____
 In one breast In both breasts
Current Status Deceased, due to breast cancer
 Deceased, due to other causes
 Living, with persistent cancer
 Living, free of known cancer

Have members of your family been told they have other types of cancer? YES NO
(If someone in your family was told she had "female cancer," please attempt to confirm if it was Ovarian)

If YES, please list:

1) Relation _____
Type of cancer _____
Current Status _____

2) Relation _____
Type of cancer _____
Current Status _____

3) Relation _____
Type of cancer _____
Current status _____

4) Relation _____
Type of cancer _____
Current status _____