



**PLEASE NOTE:** This form is for new patients only. Please fill this out only if it can't be filled out over the phone with a staff member (585-442-2190) or at our office at the appointment on one of our computer kiosks. Staff would happy to assist filling out form, over the phone or in the office.

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Purpose of today's visit?**

**Social History:**

- Gender? Female Male Gender not listed Intersex
- Sex assigned at birth? (If different) Female Male Gender not listed Intersex
- Marital Status? Single Married Divorced Domestic Partner Widowed Legally Separated Decline
- Occupation?
- Do you drink alcohol?  Yes  No How often?
- Do you smoke? Never Former Current everyday Current some day Heavy tobacco Light tobacco  
Smoker, current status unknown Unknown if ever smoked Decline to specify
- Race(s): White Black or African American American Indian or Alaska Native Asian  
Native Hawaiian or other Pacific Islander Other, race: \_\_\_\_\_ Decline to specify
- Ethnicity: Not Hispanic/Latino Hispanic/Latino Decline to specify
- Preferred Language: English Other:
- Height:
- Weight:

**Are you allergic to any of the following:**

- Medication allergies?  Yes  No Please list all medication allergies:
- Adhesive Tape?  Yes  No
- Lidocaine?  Yes  No
- Iodine Contrast Material?  Yes  No
- Latex?  Yes  No
- Others?

**Do you currently have any of the following:**

- Nipple changes  
Inversion?  Yes  No  
Discharge?  Yes  No

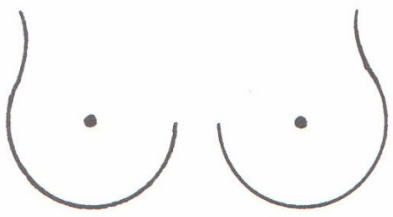
**Do you have any of the following:**

- Pacemaker / Defibrillator?  Yes  No  
Heart valve / Stent?  Yes  No

## Breast History:

- Have you had breast surgery?  Yes  No
- Breast Implants?  Yes  No
- Breast Reduction?  Yes  No
- Lumpectomy?  Yes  No
- Mastectomy?  Yes  No
- Double Incision Top Surgery?  Yes  No
- Fat Transfer/Grafting?  Yes  No When?   Left  Right  Bilateral

Please indicate where you had surgery with an "X"



RIGHT LEFT

- Radiation therapy to your breast/chest area?  Yes  No When?
- Chemotherapy?  Yes  No When?  For What?
- Have you ever had a breast biopsy?  Yes  No
- Number of breast biopsies:
- Were the biopsy results with:
- Atypical Ductal Hyperplasia (ADH)?  Yes  No **(If unsure, please answer 'No')**
- Lobular Carcinoma in situ (LCIS)?  Yes  No **(If unsure, please answer 'No')**
- Ductal Hyperplasia (UDH)?  Yes  No **(If unsure, please answer 'No')**
- Atypical Lobular Hyperplasia (ALH)?  Yes  No **(If unsure, please answer 'No')**

## Medications:

Are you taking aspirin or blood thinners?  Yes  No

List all medications you are taking:  
(include non-prescription medications and birth control pills,  
**write 'none' if no medications are used**)

## Questions for female patients:

How many months since your physician examined your breasts?

Do you have biological children?  Yes  No Your age at birth of your 1st child:

Your age at time of 1st menstrual cycle:

Are you Post-menopausal?  Yes  No Age you entered menopause:   Unknown  
(If you are no longer having periods for at least one year)

Are your periods regular?  Yes  No

Do you have your uterus?  Yes  No

Have you had your ovaries removed?  Yes  No Comment:

Hormone replacement therapy:  Never  Unknown  Previous user(over 5 years ago) How long on it:   
 Previous user(less than 5 years) How long on it:   Current User How long on it:

## Are you taking:

Birth control?  Yes  No Method:  Brand:

Anti-Estrogen/Breast Cancer Prevention?  Yes  No Brand:

Are you breast feeding?  Yes  No Are you pregnant?  Yes  No

**Risk Factors:**

Are you adopted?  Yes  No

Are you of Ashkenazi Jewish Descent (at least 10%)?  Yes  No

Have you previously pursued Genetic Testing for your Cancer Risk?  Yes  No

If outside of EWBC, Please indicate where and results:

**Personal conditions:**

No Conditions:

Condition	Age at onset	Age at recurrence	Type
<input type="checkbox"/> Breast cancer	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Secondary Breast Cancer	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Ovarian cancer	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Prostate cancer	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Melanoma	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Pancreatic cancer	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Kidney cancer	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Colon cancer	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Uterine cancer	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Thyroid cancer	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Gastric cancer	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Lymphoma			
<input type="checkbox"/> Leukemia			
<input type="checkbox"/> Stroke			
<input type="checkbox"/> Heart Attack			
<input type="checkbox"/> High Blood Pressure			
<input type="checkbox"/> Asthma			
<input type="checkbox"/> Hepatitis A			
<input type="checkbox"/> Hepatitis B			
<input type="checkbox"/> Hepatitis C			
<input type="checkbox"/> Autoimmune Disease			
<input type="checkbox"/> Liver Disease			
<input type="checkbox"/> Diabetes			
<input type="checkbox"/> Arthritis			
<input type="checkbox"/> Bleeding Disorder			

Comments regarding personal risk factors:

**Blood relatives:** Mother, Father, Daughters, Sons, Brothers, Sisters, Aunts, Uncles, Grandmothers, Grandfathers, Granddaughters, Grandsons, Nieces & Nephews

**Blood relatives with risk factors?**  Yes  No known family history

### Relative 1

Type of Relative:

Deceased:  Age at death:

Condition	Age at onset	Age at recurrence	Type
<input type="checkbox"/> Breast cancer	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Secondary Breast Cancer	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Ovarian cancer	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Prostate cancer	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Melanoma	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Pancreatic cancer	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Kidney cancer	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Colon cancer	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Uterine cancer	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Thyroid cancer	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Gastric cancer	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Lymphoma			
<input type="checkbox"/> Leukemia			

Comments regarding relative 1

### Relative 2

Type of Relative:

Deceased:  Age at death:

Condition	Age at onset	Age at recurrence	Type
<input type="checkbox"/> Breast cancer	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Secondary Breast Cancer	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Ovarian cancer	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Prostate cancer	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Melanoma	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Pancreatic cancer	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Kidney cancer	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Colon cancer	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Uterine cancer	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Thyroid cancer	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Gastric cancer	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Lymphoma			
<input type="checkbox"/> Leukemia			

Comments regarding relative 2

Please make note about any additional relatives with conditions (include age at onset, recurrence and type)

Relative 3

Relative 4

Relative 5