UCLA Health

SANTA MONICA BREAST CENTER
INTAKE FORM

MRN:
Patient Name:

(Patient Label)

Who referred you to see us today? _____

Who is your primary care physician?_____

Are there any other MDs who you would like to receive today's visit information? ☐ No ☐ Yes

MD contact info (if outside UCLA):

Please indicate any Breast Symptoms you are currently experiencing:

Mass or Lump: ☐ No ☐ Yes Nipple Discharge: ☐ No ☐ Yes

Skin Changes: ☐ No ☐ Yes Breast Pain: ☐ No ☐ Yes

Other: _____

Have you been having regular mammograms? ☐ No ☐ Yes - How often? _____

Do you do breast self-examination? ☐ No ☐ Yes - How often? _____

Prior to the current diagnosis, have you ever had a previous breast biopsy? ☐ No ☐ Yes

Prior to the current diagnosis, have you had prior breast cancer? ☐ No ☐ Yes

If yes, year diagnosed: _____

Was your prior breast cancer, ☐ Right Breast ☐ Left Breast

How was your prior breast cancer treated? ☐ Lumpectomy ☐ Mastectomy

If mastectomy, did you have reconstruction? ☐ No ☐ Yes

Did you have axillary surgery? ☐ No ☐ Yes

What type: ☐ Complete axillary lymph node dissection ☐ Sentinel lymph node biopsy

Did you receive radiation therapy? ☐ No ☐ Yes – If yes, when?

_____

Did you receive chemotherapy? ☐ No ☐ Yes

Did you receive hormone/endocrine therapy? ☐ No ☐ Yes

Have you ever had breast reduction surgery? ☐ No ☐ Yes – What year? _____

Have you ever had breast augmentation surgery? ☐ No ☐ Yes – What year? _____

Allergies: Do you have any allergies? ☐ No ☐ Yes

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Please list all allergies to medications/foods/substances/ what type of reaction you had:

Allergy/Medication	Reaction

Medications – list all medications/vitamins/supplements you are currently taking/dose/frequency:

Medication	Dose/Frequency	Prescribing Physician

Operations and Hospitalizations – Please list all operations and hospitalizations, if applicable

Surgery/Hospitalization	Date

Medical History – Please list all medical diagnoses/conditions you see doctors for or take medicines for:

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FAMILY HISTORY

Are you of Ashkenazi Jewish Descent: ☐ No ☐ Yes

Do you have a family history of breast cancer? ☐ No ☐ Yes ☐ Unknown

Which side of the family? ☐ Maternal (mother's side) ☐ Paternal (father's side)

If yes, which family member(s)?_____

Relative	Current age, if living	Age at death, if deceased	Medical Problems	History of cancer, type, treatment	Age at cancer diagnosis

Do you have a family history of ovarian cancer? ☐ No ☐ Yes ☐ Unknown

Which side of the family? ☐ Maternal (mother's side) ☐ Paternal (father's side)

If yes, which family member(s)?

Relative	Current age, if living	Age at death, if deceased	Medical Problems	History of cancer, type, treatment	Age at cancer diagnosis

Do you have a family history of other cancers? ☐ No ☐ Yes ☐ Unknown

Which side of the family? ☐ Maternal (mother's side) ☐ Paternal (father's side)

If yes, which family member(s)?

Relative	Current age, if living	Age at death, if deceased	Medical Problems	History of cancer, type, treatment	Age at cancer diagnosis

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GYNECOLOGIC HISTORY

Age at time of first menstrual cycle (first period): _____Last menstrual period? _____

Have you experienced menopause? ☐ No ☐ Yes – Age at menopause: _____

Have you had a hysterectomy? ☐ No ☐ Yes Were your ovaries removed? ☐ No ☐ Yes

How many pregnancies have you had? _____How many live births you had? _____

If premenopausal, is there any possibility that you could be pregnant? ☐ No ☐ Yes

How old were you when you first child was born? _____ Did you Breastfeed? ☐ No ☐ Yes

Have you ever taken hormone replacement therapy? ☐ No ☐ Yes

Age started: _____ Age stopped: _____

Have you ever used hormonal contraceptive methods? ☐ No ☐ Yes

Age started: _____ Age stopped: _____

Have you ever had fertility treatments? ☐ No ☐ Yes

PERSONAL/SOCIAL HISTORY

Ethnicity: ☐ Caucasian ☐ African American ☐ Spanish/Hispanic
☐ American Indian/Aleutian/Eskimo ☐ Asian/Pacific Islander ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Divorced ☐ Widowed

Do you have children? ☐ No ☐ Yes

If yes, what are their ages? _____

Are you currently employed? ☐ No ☐ Yes

If yes, what is your occupation? _____

Have you been or are you currently a cigarette smoker: ☐ No ☐ Yes

If yes, how many years did you smoke? _____ How much? _____pack/day

Are you currently smoking? ☐ No ☐ Yes

If you have quit smoking, how long ago did you quit? _____

Do you drink alcohol? ☐ No ☐ Yes – Number of drinks per day: _____ per week: _____

Describe your daily activity level: (*Mark only ONE that best describes you now):*

☐ I am fully active and am able to carry on all usual activities without restriction
☐ I am restricted in physically strenuous activity, but can walk and am able to carry on light housework
☐ I can walk and take care of myself, but am unable to carry out work activities
☐ I need help taking care of myself and I spend more than half of the day in bed or a chair
☐ I cannot take care of myself at all and spend most of the day in bed

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FORM TITLE
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Specialty/Department (if necessary)

REVIEW OF SYSTEMS: Please check off below any symptoms or problems you are currently having:

Constitutional
☐ poor appetite
☐ fatigue
☐ weight gain/loss
☐ poor sleep
☐ fever
☐ headache

Eyes
☐ blurred vision
☐ double vision
☐ tearing/watery eyes
☐ sensitivity to light

Ears, nose, mouth & throat
☐ difficulty hearing
☐ ringing in ears
☐ sinus problems
☐ nose bleeds
☐ dry mouth
☐ taste changes
☐ hoarseness
☐ pain with swallowing
☐ difficulty with swallowing

Cardiovascular
☐ chest pain
☐ irregular heart beat
☐ high blood pressure
☐ swelling of feet or ankles
☐ heart murmur
☐ Pacemaker

Respiratory
☐ shortness of breath
☐ cough
☐ coughing up blood
☐ asthma or wheezing

Gastrointestinal
☐ abdominal pain
☐ diarrhea
☐ constipation
☐ heartburn or indigestion
☐ nausea
☐ vomiting
☐ Blood in stools

Genitourinary
☐ frequent urination
☐ painful urination
☐ blood in urine
☐ leakage/ incontinence
☐ vaginal dryness

Neurologic
☐ headaches
☐ dizziness
☐ memory loss
☐ problems walking/ falls
☐ numbness/ tingling

Psychiatric
☐ depression
☐ anxiety

Hematologic/ lymphatic
☐ enlarged lymph nodes
☐ arm swelling

Skin
☐ itching
☐ easy bruising
☐ rash

Endocrine
☐ hot flashes
☐ change in tolerance to hot or cold weather
☐ excessive thirst
☐ night sweats
☐ chills

Allergic/ Immunologic
☐ allergies
☐ runny nose
☐ itchy eyes

Musculoskeletal
☐ bone pain
☐ joint pain
☐ muscle weakness

Patient or Representative Signature _____ Date _____Time _____

If signed by someone other than the patient, please specify relationship to the patient _____

Interpreter Signature _____ ID # _____ Date _____ Time _____