HONORHEALTH | comprehensive BreastCenter of Arizona PLC

COLLABORATING FOR CANCER CARE

MALE BREAST HEALTH INTAKE FORM

Name: ____________________ Age: ____ Race: ____________________
Date: ___________ Height: _________ Weight: _________ Are you of Ashkenazi Jewish heritage? Yes No

Who referred you to Dr. Duchini's office today? ____________________
Name of your family doctor: Last ________________ First ________________

Reason for your visit today:
____
____

When was your last mammogram? ____________________
Where was it done? ____________________
Have you ever had an abnormal mammogram, ultrasound, or MRI of the breast? Yes No

Can you feel, or did your doctor feel, a breast mass? Yes No
If yes, which breast is it in? Right Left Both
How long has it been there? ____________________
Is it getting larger? ____________________

Do you have any breast pain? Yes No
If yes, which breast is it in? Right Left Both
When did it start? ____________________

Do you have any nipple discharge? Yes No
If yes, which nipple is it from? Right Left Both
How long has it been going on? ____________________
What color is it? Clear Bloody Green Yellow Milky Brown
Does it come out all by itself or only when you squeeze your nipple? ____ by itself
____ when I squeeze

Have you ever had any of the following:
Breast trauma Yes No If yes, which breast was it in? Right Left
Breast Abscess Yes No If yes, which breast was it in? Right Left
Breast Infection Yes No If yes, which breast was it in? Right Left

Have you ever had a breast biopsy? Yes No
If yes, which breast? Right Left Both
When? ______________ Where was it done? ____________________
What was the result? ____________________

Have you ever had breast surgery? Yes No
If yes, which breast? Right Left Both
What procedure did you have done? ____________________
When? ____________________

Have you ever had radiation to your chest? Yes No
ie: when you were younger for Hodkins Lymphoma

Did you ever have breast cancer? Yes No
If yes, when? ___________________
Which breast? Right Left
Did you have chemotherapy? Yes No
Did you have radiation? Yes No

Have you ever had any other type of cancer? Yes No
If yes, what type did you have? ____
At what age were you diagnosed? ____

Do you drink caffeinated drinks? (coffee, tea, cola, mountain dew, chocolate)
Yes No If yes, how much? _________________________

Do you use soy products? Yes No If yes, how much? ___________

Do you smoke? Yes No
If yes, how much? _______________ For how long? _________________
If you used to smoke:
How much? _________ how long? ________ when did you quit?_______

Do you drink alcohol? Yes No
If yes, how much? __________________

Have you take in any steroids for more than 2 weeks in the past year? Yes No

Are you taking any herbal over-the-counter medicines? Yes No

Any history or high risk of having a blood borne pathogen? Yes No
Ex: Hepatitis B, Hepatitis C, HIV+/AIDS

Do you have any allergies to medications? If yes, list them below:

Medication	what happens when you take it?
______________________	______________________________
______________________	______________________________
______________________	______________________________
______________________	______________________________
______________________	______________________________
______________________	______________________________

Are you taking any medications? If so, list them below: (include any aspirin, herbal, and over the counter products)

Medication	Dose	How often?
______________________	____________	____________________
______________________	____________	____________________
______________________	____________	____________________
______________________	____________	____________________
______________________	____________	____________________
______________________	____________	____________________
______________________	____________	____________________
______________________	____________	____________________
______________________	____________	____________________

Do you have any or have had any medical conditions that you are being treated for?
Please list all conditions below including heart problems, lung problems, stroke, bleeding problems, etc.

____
____
____
____
____
____
____

Have you ever had surgery before? If yes, what surgery did you have and when?

Surgery	when
____	______________
____	______________
____	______________
____	______________
____	______________
____	______________
____	______________
____	______________

Marital Status: Single Married Divorced Widowed

Occupation: ____

Did you or a family member ever have a reaction to any kind of anesthesia? Yes No
If yes, what kind of anesthesia and what was the reaction? ___________________________________

How many children do(did) **YOU** have? Sons __________ Daughters______

How many siblings do(did) **YOU** have? Brothers_______ Sisters_________

How many siblings does(did) your **FATHER** have? Brothers_______ Sisters_________

How many siblings does(did) your **MOTHER** have? Brothers_______ Sisters_________

1. For **each** relative, fill in their first name, and as much of the requested information as possible
2. Include only blood relatives even if they are no longer living. Please note if they are "half" relatives.
3. For family members who had cancer, the type of cancer & age when they were diagnosed is very important.
   ESPECIALLY BREAST, OVARIAN, UTERINE, CERVICAL, COLON, PROSTATE, THYROID, PANCREATIC, AND MELANOMA.

RELATIVE (circle one)		**FIRST NAME**	**CANCER TYPE**	**AGE at DIAGNOSIS**	any other **CANCER RELATED** diagnosis	Status- **ALIVE** (age)	Status- **DECEASED** (age at death)
YOU							
	CHILDREN						
Daughter / Son							
Daughter / Son							
Daughter / Son							
Daughter / Son							
Daughter / Son							
	PARENTS						
Mother							
Father							
	SIBLINGS						
Sister / Brother							
Sister / Brother							
Sister / Brother							
Sister / Brother							
Sister / Brother							
	PATERNAL RELATIVES (Father's Side)						
Grandmother							
Grandfather							
Aunt / Uncle							
Aunt / Uncle							
Aunt / Uncle							
Aunt / Uncle							
Aunt / Uncle							
	MATERNAL RELATIVES (Mother's Side)						
Grandmother							
Grandfather							
Aunt / Uncle							
Aunt / Uncle							
Aunt / Uncle							
Aunt / Uncle							
Aunt / Uncle							

	ADDITIONAL INFORMATION: **ESPECIALLY BREAST, OVARIAN, UTERINE, CERVICAL, COLON, PROSTATE, THYROID, PANCREATIC, AND MELANOMA.**						
RELATIVE	MATERNAL OR PATERNAL	**FIRST NAME**	**CANCER TYPE**	**AGE** at **DIAGNOSIS**	any other **CANCER RELATED** diagnosis	Status- **ALIVE** (age)	Status- **DECEASED** (age at death)