BREAST CARE CONSULTANTS OF NORTHERN VIRGINIA
Male Breast Heath Intake Form

Today's Date: ____________________

Name: ________________________________ Birth Date: ________ Age: ____ Race: _________

Are you of Ashkenazi Jewish heritage?
Yes No

Who referred you to our office today? ____
Who is your primary care doctor? ____

History of Present Illness

How can we help you today? ____
____

Did you or your doctor feel a mass in your breast? Yes No
If yes, which breast is it in? Right Left Both
When did someone notice it? ____

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 Cheesy
Does it come out by itself or only when you squeeze your nipple? ____ By itself
____ When I squeeze

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

Have you ever had a mammogram and/or breast ultrasound? Yes No
If yes, where was it done? ___________________________________

Have you undergone a biopsy for any of the above complaints? Yes No
If yes, where? ______________________________________
When? ______________________________________
How? ______________________________________

Breast Health Risk Factors

Have you ever had a breast biopsy in the past? Yes No
If yes, how many biopsies? ___________________________________
Which breast? Right Left Both
What type of biopsy? ___________________________________
When? ______________________________________
What was the result? ___________________________________

Have you ever had breast cancer? Yes No
If yes, when? ______________________________________
Which breast? Right Left Both
What surgery did you have? Lumpectomy Mastectomy
Did you have lymph nodes removed/biopsied? Yes No
How many? ______________
Did you have chemotherapy? Yes No
Did you have hormonal treatment? Yes No
Did you have radiation? Yes No

Have you ever had radiation therapy of your neck or chest? Yes No
If yes, where and when? ____

Have any of your family members (including both your mother's and father's sides) been diagnosed with breast cancer? Yes No

If yes, who? ______________________________ Age at diagnosis ____________ Living or deceased
______________________________ Age at diagnosis ____________ Living or deceased

Have you or any family members had genetic counseling and/or genetic testing for cancer? Yes No

Have any of your family members had any of these other types of cancer? If so, who and when?

Ovarian? ______________________________ Age at diagnosis ____________
Endometrial? ______________________________ Age at diagnosis ____________
Colon ? ______________________________ Age at diagnosis ____________
Gastric? ______________________________ Age at diagnosis ____________
Thyroid? ______________________________ Age at diagnosis ____________
Prostate? ______________________________ Age at diagnosis ____________
Pancreas? ______________________________ Age at diagnosis ____________
Melanoma? ______________________________ Age at diagnosis ____________
Kidney? ______________________________ Age at diagnosis ____________
Leukemia? ______________________________ Age at diagnosis ____________
Sarcoma______________________________ Age at diagnosis ____________
Brain? ______________________________ Age at diagnosis ____________
Adrenocortical carcinoma? ______________________________ Age at diagnosis ____________

Past Medical and Surgical History

Mark any medical problems that you have or have had in the past and explain.

- ☐ Arthritis ______________________________
- ☐ Diabetes ______________________________
- ☐ Digestive Problems ______________________________
- ☐ Emphysema or Other Lung Problems ______________________________
- ☐ High Blood Pressure ______________________________
- ☐ High Cholesterol ______________________________
- ☐ Heart Problems ______________________________
- ☐ Osteoporosis ______________________________
- ☐ Stroke ______________________________
- ☐ Seizures ______________________________
- ☐ Thyroid Problems ______________________________
- ☐ Auto-immune disorders ______________________________
- ☐ Psychiatric disorders ______________________________
- ☐ Other ______________________________

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

Surgery	When

Are you taking any medications? If so, list them below:

Medication	Dose	How often?

Are you taking any herbal, over-the-counter or alternative/complementary medications, vitamins or supplements? If so, list them below:

Agent	Dose	How often?
______________________________	______	________________
______________________________	______	________________
______________________________	______	________________
______________________________	______	________________
______________________________	______	________________
______________________________	______	________________

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

Medication	What happens when you take it?
______________________________	______________________________
______________________________	______________________________

Social History

Do you consume soy products? Yes No
If yes, how much and what types? ___________________________________

Do you or have you used anabolic steroids? Yes No

Do you or have you used over-the-counter nutritional supplements or protein powders? Yes No

Do you smoke? Yes No
If yes, how much per day? ________________ For how long? ______
If you used to smoke, how much per day? ___________ For how long? ______
When did you quit? _________

Do you drink alcohol? Yes No
If yes, how much and how often? ___________________________________

Do you use marijuana? Yes No

Review of Systems

Do you have any of the following?
- ☐ Easy bruising or bleeding
- ☐ Headaches
- ☐ Fatigue
- ☐ Loss of appetite
- ☐ Weight loss
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Nausea/vomiting
- ☐ Abdominal pain
- ☐ Skin rashes or changes
- ☐ New bone or joint pain(s)

Please explain any above checked boxes ____
____