BREAST CARE CONSULTANTS OF NORTHERN VIRGINIA
Follow Up Visit Intake Form

Appointment Date: _____

Name:_____ Birth Date:_____ Age: _____

History of Present Illness

How may we help you today? _____
_____

Did you or your doctor feel any new masses in your breast? ☐ Yes ☐ No ☐ Not Applicable
If yes, which breast is it in? ☐ Right ☐ Left ☐ Both
How long has it been there? _____

Do you have any nipple discharge? ☐ Yes ☐ No ☐ Not Applicable
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 ☐ Not Applicable
If yes, which breast is it in? ☐ Right ☐ Left ☐ Both
Does it get worse around your periods? ☐ Yes ☐ No
When did it start? _____

Have you had any breast imaging since your last clinic visit? ☐ Yes ☐ No ☐ Not Applicable
If yes, what study did you have? _____
When was it done? _____

If you underwent breast surgery, do you have any swelling, heaviness, tenderness or decreased range of motion of your arm? ☐ Yes ☐ No ☐ Not Applicable

Past Medical and Surgical History

Have you been diagnosed with any new medical conditions since your last office visit? If so, list them below:
_____
_____
_____

Have you had any surgeries since your last office visit? 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 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? _____

Family History

Has anyone in your family been diagnosed with any new cancer condition(s) since your last office visit? If so, list them below:

_____

_____

_____

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: _____

_____