HONORHEALTH | comprehensive BreastCenter of Arizona PLC

COLLABORATING FOR CANCER CARE

MALE BREAST HEALTH INTAKE FORM

Name: _____ Age: ____ Race: _____

Date: _____ Height: _____ Weight: _____

Who referred you to Dr. Duchini's office today? _____

Name of your family doctor: Last _____ First_____

Reason for your visit today:_____

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? _____

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? _____

Social History

Do you consume alcohol?	❑ Yes ❑ No	If Yes, how many ounces per day?
Do you consume caffeine daily?	❑ Yes ❑ No	If Yes, how much per day?
Do you smoke? Marijuana use?	❑ Yes ❑ No ❑ Yes ❑ No	If Yes, how many packs per day? If Yes, how often?
Are you a former smoker?	❑ Yes ❑ No	If yes, how long did you smoke? If yes, when did you quit? Date: _____

Please list your MEDICATIONS AND VITAMINS (include any aspirin, herbal, and over the counter products) Dose and how often?	
1.	11.
2.	12.
3.	13.
4.	14.
5.	15.
6.	16.
7.	17.
8.	18.
9.	19.
10.	20.

Please list your ALLERGIES TO MEDICATIONS			
❑ No Known Allergies	❑ Penicillin Reaction:	❑ Sulfa Reaction:	❑ Codeine Reaction:
	❑ Latex Reaction:	❑ Iodine Reaction:	❑ Adhesive Reaction:
Other allergies with reactions:			

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

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

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

Past Medical History

❑ Yes ❑ No	Acid Reflux of Stomach (GERD)	❑ Yes ❑ No	Heart Disease
❑ Yes ❑ No	Acute Myocardial Infarction (Heart Attack)	❑ Yes ❑ No	High Cholesterol or High Lipids
❑ Yes ❑ No	Anemia	❑ Yes ❑ No	Hypertension (High Blood Pressure)
❑ Yes ❑ No	Asthma	❑ Yes ❑ No	Hypothyroidism (Low Thyroid)
❑ Yes ❑ No	Atrial Fibrillation	❑ Yes ❑ No	Kidney Disease
❑ Yes ❑ No	Autoimmune Disease Type: _____	❑ Yes ❑ No	Obesity
❑ Yes ❑ No	Blood Dyscrasias (Blood Clotting Disorder) Type: _____	❑ Yes ❑ No	Osteoporosis
❑ Yes ❑ No	Cancer, Breast	❑ Yes ❑ No	Parkinson's Disease
❑ Yes ❑ No	Cancer, Other Type: _____	❑ Yes ❑ No	Sleep Apnea
❑ Yes ❑ No	COPD	❑ Yes ❑ No	Seizures
❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Transient ischemic attack (stroke)
❑ Yes ❑ No	Emphysema	❑ Yes ❑ No	Other Medical Problem(s):
❑ Yes ❑ No	Other Medical Problem(s):	❑ Yes ❑ No	Other Medical Problem(s):
❑ Yes ❑ No	Other Medical Problem(s):	❑ Yes ❑ No	Other Medical Problem(s):

Surgical History

❑ Yes ❑ No	Hysterectomy with both ovaries removed		Date: _____
❑ Yes ❑ No	Hysterectomy with one ovary removed Side of removal: ❑Left ❑Right		Date: _____
❑ Yes ❑ No	Breast Biopsy	❑ Left side Date:	❑ Right side Date:
❑ Yes ❑ No	Breast Lumpectomy	❑ Left side Date:	❑ Right side Date:
❑ Yes ❑ No	Breast Mastectomy	❑ Left side Date:	❑ Right side Date:
❑ Yes ❑ No	Appendectomy (Appendix Removed)		Date:
❑ Yes ❑ No	Bladder Surgery		Date: _____
❑ Yes ❑ No	Brain Surgery		Date: _____
❑ Yes ❑ No	Breast Augmentation		Date: _____
❑ Yes ❑ No	Breast Reduction		Date: _____
❑ Yes ❑ No	Carotid Endarterectomy		Date: _____
❑ Yes ❑ No	Cesarean Section		Date: _____
❑ Yes ❑ No	Cholecystectomy (Gallbladder Removal)		Date: _____
❑ Yes ❑ No	Cataract removal		Date: _____
❑ Yes ❑ No	Dental surgery		Date: _____
❑ Yes ❑ No	Heart surgery		Date: _____
❑ Yes ❑ No	Nephrectomy (Kidney Removal)		Date: _____
❑ Yes ❑ No	Tonsillectomy		Date: _____
❑ Yes ❑ No	Total Joint Replacement Type: _____ Side of replacement: ❑Left ❑Right		Date: _____
❑ Yes ❑ No	Transplant (Kidney, Heart, Lung, Liver, etc.) Side of transplant (if applicable): ❑Left ❑Right		Date: _____
❑ Yes ❑ No	Other Surgery Type: _____		Date: _____
❑ Yes ❑ No	Other Surgery Type: _____		Date: _____

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_____

For each relative, fill in their first name, and as much of the requested information as possible Include only blood relatives even if they are no longer living. Please note if they are "half" relatives. 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							
	PARENTS						
Mother							
Father							
	SIBLINGS						
Sister / Brother							
Sister / Brother							
Sister / Brother							
Sister / Brother							
	PATERNAL RELATIVES (Father's Side)						
Grandmother							
Grandfather							
Aunt / Uncle							
Aunt / Uncle							
	MATERNAL RELATIVES (Mother's Side)						
Grandmother							
Grandfather							
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)