Great Lakes Cancer Care Collaborative

Stuti J. Tambar, MD
Breast Surgeon
192 Park Club Lane, Ste. 120
Williamsville, NY 14221

greatlakescancercare.org
T 716-884-3000
F 716-422-0018

Please complete this form prior to your appointment and bring it with you to your appointment. You can also fax this form to 716-422-0018.

LAST NAME | FIRST NAME | DATE OF BIRTH | AGE

ETHNICITY/RACE

Are you of Ashkenazi Jewish heritage? ❑ Yes ❑ No

Reason for consultation: _____

LIST YOUR PHYSICIANS

Use additional pages if needed. Check box if provider is to receive a copy of today's consultation.

❑ NAME | SPECIALTY | ADDRESS | PHONE#

❑ NAME | SPECIALTY | ADDRESS | PHONE#

❑ NAME | SPECIALTY | ADDRESS | PHONE#

❑ NAME | SPECIALTY | ADDRESS | PHONE#

PHARMACY

NAME | ADDRESS | PHONE# AND FAX#

BREAST HEALTH

Do you have any of the following? If yes, check right, left or both.

Breast Lump	❑ Yes	❑ No	❑ Right	❑ Left	❑ Both
Nipple Discharge	❑ Yes	❑ No	❑ Right	❑ Left	❑ Both
Nipple Inversion	❑ Yes	❑ No	❑ Right	❑ Left	❑ Both
Breast Trauma	❑ Yes	❑ No	❑ Right	❑ Left	❑ Both
Breast Pain	❑ Yes	❑ No	❑ Right	❑ Left	❑ Both
If "yes", is the pain related to periods?	❑ Yes	❑ No			
Have you had any breast cyst aspirated?	❑ Yes	❑ No	❑ Right	❑ Left	❑ Both

Patient Name _____ Date of Birth _____

Have you had any prior breast surgery? ❑ Yes ❑ No

Type of Surgery: ❑ Biopsy ❑ Lumpectomy ❑ Mastectomy

If "yes", check side(s), list diagnosis, year(s) and where the surgery was performed:

❑ **Left Diagnosis**

YEAR(S) WHERE

❑ **Right Diagnosis**

YEAR(S) WHERE

Have you had a mammogram? ❑ Yes ❑ No

If "yes", when and where was the last mammogram performed?

WHEN WHERE

What is your Bra size? _____

GYNECOLOGIC HISTORY

AGE WHEN MENSTRUAL PERIODS BEGAN | DATE OF FIRST DAY OF LAST MENSTRUAL PERIOD | IF, MENOPAUSAL, AT WHAT AGE DID THAT BEGIN?

NUMBER OF TIMES PREGNANT | NUMBER OF CHILDREN BORN | AGE AT FIRST FULL-TERM PREGNANCY

Did you breast feed? ❑ Yes ❑ No If "yes", then for how many months? _____

Are you currently pregnant? ❑ Yes ❑ No

Have you ever taken birth control pills? ❑ Yes ❑ No

If "yes", then when were they started and stopped?

STARTED STOPPED

Have you ever taken any other hormones? ❑ Yes ❑ No

If "yes", give type, duration and when stopped:

TYPE

DURATION STOPPED

Date of your last gynecological check-up: _____

Results of last PAP test ❑ Normal ❑ Abnormal ❑ Not Applicable

Are you interested in having more children? ❑ Yes ❑ No

MEDICATIONS

Are you currently taking any medication? ❑ Yes ❑ No

If "yes", please list the medication(s), dosage and times taken per day. Use more pages as needed.

NAME DOSAGE FREQUENCY

Patient Name _____ Date of Birth _____

ALLERGIES

Are you allergic to any medications? ❑ Yes ❑ No
If "yes", please name the medications:

_____

_____

_____

Do you have latex allergy? ❑ Yes ❑ No
Do you have other allergies? ❑ Yes ❑ No
(such as food or environmental)
If "yes", please list other allergies:

_____

_____

MEDICAL HISTORY - check all that apply and note date diagnosed

- ❑ Cancer - Type: _____
- ❑ Chronic Renal Failure
- ❑ DVT/Blood Clots
- ❑ HIV
- ❑ Kidney Disease
- ❑ Osteoarthritis
- ❑ Hepatitis-Type: _____
- ❑ High Blood Pressure
- ❑ High Cholesterol/Lipids
- ❑ Seizure
- ❑ Stroke
- ❑ Thyroid Disorder
- ❑ Osteoporosis
- ❑ Radiation Treatment or Exposure
- ❑ Diabetes – Circle Type 1 or 2
- ❑ Heart Attack (MI)
- ❑ Liver Disease

Other medical history: please describe: _____

_____

_____

SURGICAL HISTORY

Have you ever had surgery? ❑ Yes ❑ No
If "yes", please list type of surgery and year. (Use additional pages as needed)

TYPE OF SURGERY	YEAR PERFORMED

FAMILY HISTORY

Do you have family history of breast cancer? ❑ Yes ❑ No
If "yes", list below relative, age at initial diagnosis and whether one or both breast were affected.

RELATIVE	PATERNAL/MATERNAL	"AGE AT DIAGNOSIS"	ONE OR BOTH BREASTS?	CURRENT STATUS
RELATIVE	PATERNAL/MATERNAL	"AGE AT DIAGNOSIS"	ONE OR BOTH BREASTS?	CURRENT STATUS
RELATIVE	PATERNAL/MATERNAL	"AGE AT DIAGNOSIS"	ONE OR BOTH BREASTS?	CURRENT STATUS

Patient Name _____ Date of Birth _____

Has any blood relative had any other type of cancer? ❑ Yes ❑ No

RELATIVE	PATERNAL/MATERNAL	"AGE AT DIAGNOSIS"	TYPE OF CANCER	CURRENT STATUS
RELATIVE	PATERNAL/MATERNAL	"AGE AT DIAGNOSIS"	ONE OR BOTH BREASTS?	CURRENT STATUS
RELATIVE	PATERNAL/MATERNAL	"AGE AT DIAGNOSIS"	ONE OR BOTH BREASTS?	CURRENT STATUS

SOCIAL HISTORY

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Other: _____

Have you ever smoked? ❑ Yes ❑ No

If "yes indicate duration in years:

YEAR STARTED	YEAR STOPPED	# PACKS/DAY

Do you exercise regularly? ❑ Yes ❑ No

If so, how often? _____

Do you eat or drink foods containing caffeine? ❑ Yes ❑ No
(For example: coffee, tea, soda or chocolate)

If "yes" list average daily consumption _____

Do you drink alcohol? ❑ Yes ❑ No

If "yes", average number of drinks per day _____

Occupation (or prior occupation if not working) _____

Email address: _____

ADDITIONAL INFORMATION

PLEASE SIGN YOUR NAME		DATE
REVIEWED WITH PATIENT	PROVIDER	DATE

Thank you for taking the time to complete this form.

Patient Name _____ Date of Birth _____

REVIEW OF SYSTEMS

Please check any of the symptoms that you are experiencing **NOW**:

General Symptoms
- ❑ None
- ❑ Activity Intolerance
- ❑ Dizziness
- ❑ Drooling
- ❑ Edema
- ❑ Faintness
- ❑ Fatigue
- ❑ Heartburn
- ❑ Itching
- ❑ Nausea
- ❑ Weakness
- ❑ Other: _____

_____

Respiratory Symptoms
- ❑ None
- ❑ Difficulty Breathing at Rest
- ❑ Difficulty Breathing with Activity
- ❑ Shortness of Breath
- ❑ Cough
- ❑ Other: _____

_____

Gastrointestinal Symptoms
- ❑ None
- ❑ Loss of Appetite
- ❑ Bloating
- ❑ Constipation
- ❑ Cramping
- ❑ Diarrhea
- ❑ Distention (Swelling of the Stomach)
- ❑ Flatulence (Gas)
- ❑ Hemorrhoids
- ❑ Incontinence
- ❑ Black/Bloody Stools
- ❑ Vomiting
- ❑ Blood in Vommit
- ❑ Other: _____

_____

Cardiovascular Symptoms
- ❑ None
- ❑ Chest Pain/Pressure at Rest
- ❑ Chest Pain/Pressure with Activity
- ❑ Claudication (Leg Pain with Activity)
- ❑ Cough
- ❑ Fluid Retention
- ❑ Palpitations (Fast Heartbeat)
- ❑ Other: _____

_____

Genitourinary Symptoms
- ❑ None
- ❑ Anuria (Lack of Urination)
- ❑ Dribbling
- ❑ Dysuria (Pain with Urination)
- ❑ Frequency Increase
- ❑ Hematuria (Blood in Urine)
- ❑ Incontinence
- ❑ Nocturia (Waking Up at Night to Urinate)
- ❑ Polyuria (Increased Urine Output)
- ❑ Retention
- ❑ Urgency
- ❑ Other: _____

_____

Skin Symptoms
- ❑ None
- ❑ Change in Skin Color
- ❑ Itching
- ❑ Other: _____

_____

Neuromuscular Symptoms
- ❑ None
- ❑ Hemiparesis/Weakness
- ❑ Joint Stiffness
- ❑ Joint Swelling
- ❑ Tremors
- ❑ Other: _____

_____

Neurological Symptoms
- ❑ None
- ❑ Concentration Difficulty
- ❑ Confusion/Disorientation
- ❑ Drowsiness
- ❑ Memory Problems
- ❑ Numbness
- ❑ Tingling
- ❑ Visual Changes
- ❑ Other: _____

_____

Psychosocial Symptoms
- ❑ None
- ❑ Anxiety
- ❑ Depression
- ❑ Mania
- ❑ Suicidal
- ❑ Delusional
- ❑ Hallucinations
- ❑ Other: _____

_____

Eye Symptoms
- ❑ None
- ❑ Recent Visual Problems
- ❑ Icterus (Yellow Eye)
- ❑ Discharge
- ❑ Blurring
- ❑ Visual Disturbance
- ❑ Other: _____

_____

Endocrine Symptoms
- ❑ None
- ❑ Excessive Thirst
- ❑ Excessive Urination
- ❑ Cold Intolerance
- ❑ Heat Intolerance
- ❑ Excessive Hunger
- ❑ Other: _____

_____