1. Purpose of today’s visit: ________________________________

2. Gender: ❑Male ❑Female ❑Gender not listed  3. Sex assigned at birth (if different) ❑Male ❑Female ❑Intersex

4. Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Domestic Partner ❑Legally Separated

5. Occupation: ________________________________ 6. Do you drink alcohol? ❑No ❑Yes, how often: ______________

7. Smoking status: ❑Current, every day ❑Current, some day smoker ❑Former smoker ❑Never smoker ❑Denied ❑Smoker, current status unknown ❑Unknown if ever smoked ❑Heavy tobacco smoker ❑Light tobacco smoker

8. Race: ❑White ❑African American ❑American Indian or Alaska Native ❑Asian ❑Native Hawaiian or Pacific Islander ❑Other, race: _____________________________ 9. Height _____ Weight _____

10. Ethnicity: ❑Not Hispanic/Latino ❑Hispanic/Latino  11. Preferred Language: ❑English ❑Other__________

12. How many months since your last clinical breast exam by a healthcare provider? _____


14. Please check box if you are currently experiencing:
   ❑Breast cysts ❑Breast pain ❑Nipple changes ❑Nipple Inversion ❑Nipple Discharge ❑Nipple rash

15. Are you currently using Anti-Estrogen Breast Cancer Prevention? ❑No ❑Yes, brand: __________

16. Are you currently pregnant? ❑No ❑Yes  17. Are you currently breastfeeding? ❑No ❑Yes

18. Have you had breast surgery? ❑No (please skip to question 19)
   ❑Yes (please mark on diagram to the right AND check off below what applies to you)
   ❑Breast implants? type: ❑silicone gel ❑saline ❑combination ❑unknown ☐Reduction?
   ☐Mastectomy? ☐Right ☐Left ☐Bilateral
   ☐Double incision top surgery?
   ☐Lumpectomy? ☐Right ☐Left
   ☐Breast Cancer? ☐Right ☐Left ☐Bilateral
   ☐Radiation therapy to your breast chest area, when? ______________
   ☐Chemotherapy, when? ______________ for what? __________________

19. Have you ever had a breast biopsy? ❑No ❑Yes, # of breast biopsies: _____
   Biopsy Results: (If unsure, please don’t check)
   ❑Atypical Ductal Hyperplasia (ADH) ❑Lobular Carcinoma in situ (LCIS)
   ❑Ductal Hyperplasia (UDH) ❑Atypical Lobular Hyperplasia (ALH)

20. Age of first menstrual cycle? _____  Are your periods regular ❑No ❑Yes

21. Are you post menopausal? ❑No ❑Yes, age entered menopause: ______

22. Hormone replacement? ❑No ❑Yes, usage: ❑never ❑unknown ❑used over 5 years ago
   ❑less than 5 yrs ago ❑current  22b. Length of time on HRT? _____ months _____ years

23. Do you have biological children? ❑No ❑Yes, age you were when you gave birth to your first child: _____

24. Have you had both of your ovaries removed? ❑No ❑Yes  24b. Do you have your uterus? ❑No ❑Yes

25. Are you allergic to any of the following? (Please check all that apply and specify reaction)
   ❑Medications ____________ ❑Iodine contrast material ____________ ❑Adhesive tape ____________
   ❑Lidocaine ____________ ❑Latex ____________ ❑MRI Contrast ❑Other(s) ______________

26. Do you take aspirin or blood thinners? ❑No ❑Yes, please specify: ____________________________

(over)
27. Current Medications (include non-prescription medications, write “none” if no medications are used)

__________________________________________    ________________________    ________________________    ________________________

__________________________________________    ________________________    ________________________    ________________________

28. PERSONAL HISTORY (please check if applies to YOU)

❑ Stroke          ❑ Hepatitis B          ❑ Bleeding Disorder          ❑ Leg swelling
❑ Heart Attack    ❑ Hepatitis C          ❑ Depression              ❑ Pacemaker/defibrillator
❑ High Blood Pressure ❑ Liver Disease        ❑ Eye problems            ❑ Seasonal allergies
❑ Asthma          ❑ Diabetes              ❑ Fever or Chills          ❑ Stomach problems
❑ Hepatitis A     ❑ Arthritis            ❑ Heart valve/stent        ❑ Weakness/dizziness, fainting

29. HISTORY of CANCER (YOU & your relatives)

Yourself, Mother, Father, Daughters, Sons, Brothers, Sisters, Aunts, Uncles, Grandmothers, Grandfathers, Granddaughters, Grandsons, Nieces & Nephews

<table>
<thead>
<tr>
<th>CANCER TYPE</th>
<th>RELATIVE</th>
<th>SIDE OF FAMILY (Mother or Father)</th>
<th>AGE at diagnosis</th>
<th>AGE at recurrence</th>
</tr>
</thead>
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<tr>
<td>Colon</td>
<td>Grandmother</td>
<td>M</td>
<td>45</td>
<td>deceased</td>
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<tr>
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<td>M</td>
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<tr>
<td>Colon</td>
<td>Grandmother</td>
<td>M</td>
<td>90</td>
<td>deceased</td>
</tr>
</tbody>
</table>

30. Are you adopted? ❑ No ❑ Yes

31. Are you of Ashkenazi Jewish descent (at least 10% or more)? ❑ No ❑ Yes

32. Have you previously pursued Genetic Testing for your Cancer Risk outside of EWBC? ❑ No ❑ Yes

If YES please indicate where you were tested and the results: ____________________________

The above information is accurate and any unanswered questions are considered not applicable or negative.

First Name (print): ____________________________ Last Name (print): ____________________________ Sign Name: ____________________________

Name you would like to be addressed by if different than above: ____________________________ Date of Birth: __________

Today’s Date: __________ E-Mail Address: ____________________________

FOR OFFICE USE ONLY ❑ All other systems negative

MD Review: ____________________________ Date: _______ | MD Review: ____________________________ Date: _______