Maui Pacific Cancer Institute

(808) 249-1600 | Fax (808) 249-1651 | 227 Mahalani Street, Wailuku, HI 96793-2526

Name:___________________________

ADDITIONAL INFORMATION FOR THOSE WITH A BREAST CANCER DIAGNOSIS

Your age at time of diagnosis: ______
Your weight at time of diagnosis: ______
Are you of Ashkenazi Jewish descent? _______

ADDITIONAL PERSONAL MEDICAL HISTORY

Have you ever been diagnosed with breast cancer (before this most recent diagnosis)? If so, please include which side, when you were diagnosed and what treatments you received: __________________
____
____

Have you had any previous breast biopsies? If so, please include which side, when these took place and the results: ____
____

Have you ever been diagnosed with any other cancer? If so, please specify and include when you were diagnosed, the age you were at the time of diagnosis and what treatments you received:
____
____

Have you had genetic testing related to this cancer or any other cancer? If so, please tell us when and where the testing was done and what the result was (including BRCA1 and BRCA2 status, if known).
____
____

Have you ever received radiation therapy before? If so, please add details including when this occurred:
____
____

Do you have a pacemaker? ______ If so, who is your cardiologist? ______________________________

Have you ever been diagnosed with a connective tissue disease such as systemic lupus erythematosus (“Lupus”), systemic sclerosis (“scleroderma”), or mixed connective tissue disease? __________________
If so, please specify and note when you were diagnosed: ____
____

Do you drink alcohol? ______ If so, how much (average drinks per week)?___________ and for how long? _______________ If you no longer drink alcohol, when did you quit?_______________________

Menstrual history (please complete even if post-menopausal or no longer having periods)

Age of first period: _______
If post-menopausal, age at the time of menopause: _______

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Obstetrical history:

Have you ever been pregnant? ______ If so, please answer the following questions:
Number of pregnancies: _______
Number of live births: _______
Your age at time of first pregnancy: _______

Hormone use history:

Have you ever used birth control pills? _______ If so, for how long? ______________________________
Have you ever used hormone replacement therapy? _______ If so, when and for how long? __________
____

ADDITIONAL FAMILY MEDICAL HISTORY

Has anyone in your family ever been diagnosed with breast cancer (men included)? If so, please include:

Who (how you are related)	Age at the time of diagnosis
____	______________________
____	______________________
____	______________________
____	______________________
____	______________________

Has anyone in your family ever been diagnosed with ovarian cancer? If so, please include:

Who (how you are related)	Age at the time of diagnosis
____	______________________
____	______________________
____	______________________
____	______________________
____	______________________

Has anyone in your family ever been diagnosed with uterine cancer? If so, please include:

Who (how you are related)	Age at the time of diagnosis
____	______________________
____	______________________
____	______________________
____	______________________
____	______________________

Has anyone in your family ever been diagnosed with colon cancer? If so, please include:

Who (how you are related)	Age at the time of diagnosis
____	______________________
____	______________________
____	______________________
____	______________________
____	______________________

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Do you have a close relative with a known BRCA mutation? If so, please include:
Who (how you are related)

____
____
____
____
____