BCCP INTAKE

Name ____Date ______/______/ _______

Age_________________Date of Birth______/______/_______Gender   Female   Male

Address ____

City________________________ State___________Zip Code _____________ Are you an OR resident?   Yes   No

Telephone: (h) ____________________ (c) ______________________________ (w)__________________________ ____

Circle the best phone number to reach you. Is it ok to leave a message? Yes No Email______________________ _____

Occupation: ____ Hours worked per week: _________________

Education level____ _______________________________________

Height: ____'____"   Current Weight: _____lbs. Weight one year ago: _____lbs. Max. Weight: _____lbs. When? ______

Have you been enrolled in the BCCP program before? (Circle one)   Yes No   Date:____________________________

If yes, who was the healthcare provider?____

How did you hear about the program?____

Marital Status: Single______ Married _______Partnered_______ Widowed_______Separated _______Divorced _____

Living with: Alone______ Spouse ______ Partner ________Family _______ Roommate(s)_______ Other _________

How many people live in your household?   ________________

What hospitalizations or surgeries have you had? ____

____

____

____

Do you have any allergies to foods, drugs or environmental substances? ______________________________________

____

____

____

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What diagnostic imaging studies have you had? (Please mark all that apply)

___ X-rays ____ Electrocardiogram
___ CT scan ____ Electroencephalogram
___ MRI ____ Mammogram
___ Other: ___________________________

Are you sexually active? (Circle one) Yes No

Sexual orientation: ____

Do you use birth control? (Circle one) Yes No

If yes, which form? ____

Which method(s) have you used in the past:
Pill Natural family planning IUD Diaphragm/cervical cap Condoms

Have you had any sexually transmitted infections? If so, which ones?______________________________

____

____

Y= Experience currently N=Never P=Past

Y N P Bleeding between periods
Y N P Pain during intercourse
Y N P Painful menses
Y N P Irregular cycles
Y N P Excessive flow
Y N P Menopausal symptoms
Y N P Sexual difficulties
Y N P Vaginal discharge or odor
Y N P Ovarian cysts
Y N P Endometriosis
Y N P Nipple discharge
Y N P PMS

Age at which menses began: _______
Age of last menses years
Average length of cycle days
Duration of bleeding days
Date of last menstrual period________________
Date of your last pap smear________________
Do you have a history of abnormal pap smears (circle one)
Yes No
Number of pregnancies:_____________
Number of live births:________________
Number of miscarriages:___________________
Number of abortions:________________
Have you ever had trouble conceiving? (Circle one)
Yes No

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Breasts				
0	1	2	P	Lumps
0	1	2	P	Pain or Tenderness
0	1	2	P	Discharge

0=Never, 1=Sometimes, 2=Often P=Past

Do you do self-exams? (Circle one) Yes No

Did you breast feed any of your children? (Circle one) Yes No If yes, how long?________________________

Have you ever had a mammogram? (Circle one) Yes No

If yes, date of prior mammogram:____________________________________

Have you ever had an ultrasound?

If yes, date of prior ultrasound:______________________________________

Have you ever had any other form of breast imaging?

If yes, list form of imaging and date:_________________________________

Have you ever used any kind of hormone replacement therapy? (Circle one) Yes No

If yes, what kind: ____

Are you experiencing any symptoms, or have you noticed any changes in your breasts? Please describe:

____

Have you had any surgeries to your breasts? (please circle all that apply)

Implants If yes, date of surgery(ies): ____

Reductions If yes, date of surgery(ies):____

Biopsies If yes, date of surgery(ies):____

Other If yes, describe and provide date:____

Do you have a 1st degree relative with breast cancer? (Circle one) Yes No

Do you have a personal history of breast cancer? (Circle one) Yes No

Self and Family History - Please indicate the health status of you and your family

	Self	Father	Mother	Brother 1	Brother 2	Brother 3	Sister 1	Sister 2	Sister 3	Mother's Father	Mother's Mother	Father's Father	Father's Mother
Age (at death)													
Cause of death													
Age (if living)													
Health (Good, Poor)													

List any significant health concerns of any of your family member:________________________________

____