



Breast Cancer Questionnaire

Name:		Date of Birth:		Oncologist:	
What date were you first diagnosed with breast cancer?				Tumor size (in cm):	
Left Breast <input type="checkbox"/>	Right Breast <input type="checkbox"/>	Upper Outer <input type="checkbox"/>	Lower Outer <input type="checkbox"/>	Upper Inner <input type="checkbox"/>	Lower Inner <input type="checkbox"/>
How many lymph nodes were tested?					
How many lymph nodes were positive for cancer?					
Were the tumor cells:		estrogen receptor (ER) positive: Yes <input type="checkbox"/> , No <input type="checkbox"/> , don't know <input type="checkbox"/>	progesterone receptor positive: Yes <input type="checkbox"/> , No <input type="checkbox"/> , don't know <input type="checkbox"/>	HER2/neu: Yes <input type="checkbox"/> , No <input type="checkbox"/> , don't know <input type="checkbox"/>	eGFR: Yes <input type="checkbox"/> , No <input type="checkbox"/> , don't know <input type="checkbox"/>
When you were first diagnosed, was the cancer in other organs (metastatic)? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please mark which below:					
Spine <input type="checkbox"/>	Other Bones <input type="checkbox"/>	Liver <input type="checkbox"/>	Lymph Nodes <input type="checkbox"/>	Lung <input type="checkbox"/>	Brain <input type="checkbox"/>
How were you initially treated? Please mark all that apply and include dates:					
Lumpectomy <input type="checkbox"/>	Mastectomy <input type="checkbox"/>	Removal of ovaries <input type="checkbox"/>	Radiation <input type="checkbox"/>	Chemotherapy <input type="checkbox"/>	Other _____
Breast cancer type: Carcinoma <input type="checkbox"/> , Comedocarcinoma <input type="checkbox"/>					
Were the tumor cells: In Situ <input type="checkbox"/> , Infiltrating <input type="checkbox"/> , Ductal <input type="checkbox"/> , Lobular <input type="checkbox"/> , Tubular <input type="checkbox"/> , Mucinous <input type="checkbox"/> , Papillary <input type="checkbox"/> , Don't know <input type="checkbox"/>					
To the best of your recollection, which chemotherapy drugs have you been given?					
How many doses of each?					
When were these started and completed?					
Which hormonal drugs have you been given (e.g., Tamoxifen, Femara, Raloxifen)?					
How many doses of each?					
When were these started and completed?					

<p>Have you developed any recurrences or metastases since the original diagnosis and treatment? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, please give as much detail as possible on location, tumor type and treatment:</p>				
<p>Have you developed any other medical problems since first diagnosed with breast cancer (please explain)?</p>				
<p>Have you had any of the following (give dates)?</p>		<p>Birth Control Pills <input type="checkbox"/></p>	<p>Growth Hormone <input type="checkbox"/></p>	<p>Infertility Treatments <input type="checkbox"/></p>
<p>Hormone Replacement Therapy (HRT) <input type="checkbox"/></p> <p>Estrogen <input type="checkbox"/></p> <p>Progesterone/Progestin <input type="checkbox"/></p>	<p>Other hormone therapy (specify) <input type="checkbox"/></p>	<p>PMS <input type="checkbox"/> (Mild <input type="checkbox"/>, Moderate <input type="checkbox"/>, Severe <input type="checkbox"/>)</p>		<p>Breast Pain <input type="checkbox"/></p>
<p>What was your approximate date of :</p>	<p>First menses</p>	<p>Menopause (if applicable)</p>	<p>Natural Menopause <input type="checkbox"/></p>	<p>Surgical Menopause <input type="checkbox"/></p>
<p>How many of the following have you had? Please give approximate dates.</p>		<p>Pregnancies _____</p>	<p>Miscarriages _____</p>	<p>Abortions _____</p>
<p>How many babies did you breast feed and for how long?</p>				
<p>Have you been tested for BRCA1 <input type="checkbox"/>, BRCA2 <input type="checkbox"/>? If so, what were the results?</p>				
<p>Did you even receive a Hepatitis B Vaccination? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please give approximate date(s):</p>				
<p>What other vaccinations have you received (include approximate dates)?</p>				
<p>How did you hear about EIMC?</p>				