



Bay Area Breast Surgeons, Inc.  
*A Partnership for Breast Health*

Lisa Bailey, MD, FACS  
Jon Greif, DO, FACS  
Lana Louie, MD  
Carolyn Bernstein, RN, NP  
3300 Webster Street, Suite 212  
Oakland, Ca 94609  
Phone 510-835-9900  
Fax 510-835-9909

**Patient Intake Form**

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

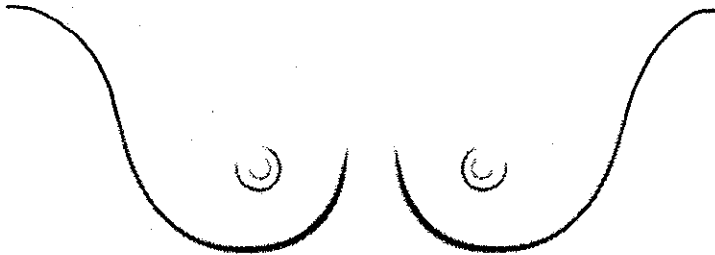
**Reason for Today's Visit:**

Palpable Mass       Breast Skin Changes  
 Nipple discharge       Abnormal Mammogram  
 Breast Pain

I first noted this problem (approximate date): \_\_\_\_\_

Date of most recent mammogram \_\_\_\_\_

Please indicate on this diagram where your abnormality is located:



Have you had any prior Breast Problems or Breast Biopsies? Please list here: \_\_\_\_\_

**Menstrual History:**

How old were you when you had your first period? \_\_\_\_\_

Date of your last Menstrual Period \_\_\_\_\_

Are your periods regular? Yes / No

Age at Menopausal? \_\_\_\_\_

Have you taken Birth Control Pills? **Yes / No**  
If yes, at what age did you start \_\_\_\_\_ stop \_\_\_\_\_.

Have you ever taken Hormone Replacement Therapy? **Yes / No**  
If yes, how long? from \_\_\_\_\_ until \_\_\_\_\_.  
Which medications have you taken? \_\_\_\_\_

Have you ever taken hormones for any other reason (e.g. Fertility drugs, DES, etc.)? **Yes / No**  
If yes, which medications? \_\_\_\_\_ how many cycles? \_\_\_\_\_

Were you ever exposed to radiation for anything other than a routine x-ray? **Yes / No**  
If yes, what kind? \_\_\_\_\_

**Reproductive History:** How many pregnancies have you had? \_\_\_\_\_. How many deliveries? \_\_\_\_\_  
Age at first delivery? \_\_\_\_\_. Did you breast feed? **Yes / No** If yes, How long? \_\_\_\_\_

**Family Medical History:** List family members who have had breast cancer, with relationship and the age at which they had breast cancer (e.g. mother 35, mother's sister 42, father's mother 85):

**Has any other family member had any other cancers? (List type, relation, age):**

**SOCIAL HISTORY:**

Occupation \_\_\_\_\_  
With whom do you live? \_\_\_\_\_

Have you ever smoked cigarettes? **Yes / No**  
If yes, How long? from \_\_\_\_\_ until \_\_\_\_\_. Amount per day \_\_\_\_\_

Do you drink alcohol? **Yes / No**  
If yes, how much? \_\_\_\_\_ per day /week / month.

Do you use marijuana? **Yes / No**  
Other substances? \_\_\_\_\_

**Pain:** Do you experience pain as part of your daily life? **Yes / No**  
If yes, describe the location, onset, duration and characteristics (ache, burn, throb, sharp)

If yes, scale it from 1-10, (10 being the worst). Rate your pain \_\_\_\_\_.  
How do you treat the pain? \_\_\_\_\_

**Domestic Violence:** Have you ever felt unsafe or been afraid of anyone? **Yes / No**  
Has anyone ever hurt or threatened to hurt you or someone else that you care about? **Yes / No**

**Past Medical History:** Circle past and present medical conditions

Anemia   Anxiety   Arthritis   Asthma   Bleeding problems   Cancer  
Depression   Diabetes   Emphysema/ Lung Disease   Gastroesophageal Reflux  
Gout   Hepatitis   High blood pressure   High cholesterol  
Heart disease/attack   Infections (chronic)   Inflammatory bowel disease  
Kidney Disease   Obesity   Pancreatitis   Seizures   Thyroid disease  
Stroke   Tuberculosis   Ulcer Disease  
Other \_\_\_\_\_

**Past Surgical History** (List operation and date/age):

**Current Medications, Vitamins and Supplements** (include dose and frequency):

**Do you have any Medication Allergies?** Please list the medication and the reaction to the medication

\_\_\_\_\_

\_\_\_\_\_

**Review of Systems:** Circle any symptoms you have:

Chest pain   Shortness of breath   Cough   Constipation  
Diarrhea   Dizziness   Nausea   Abdominal Pain

Any new pain – location? \_\_\_\_\_

Notes:

Patient Signature \_\_\_\_\_

I have reviewed this document with the patient.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_