UW Medicine
VALLEY
MEDICAL CENTER

Patient Name ___________________________________

Below is information regarding your upcoming appointment in the Breast Multidisciplinary Clinic (MDC). You must bring your ***health history form*** (attached) to the appointment, along with a complete list of medications you are currently taking – please include dosing and directions. Because exam room space is limited, we ask that you ***please bring NO MORE THAN 2 people with you*** to this appointment (thank you for your understanding). ***Please disregard ALL automated appointment reminders for these providers based on the appointment date listed below ONLY.***

Appointment location: Radiation Oncology (See attached map)

Physicians you're scheduled to see:

Medical Oncology:

Radiation Oncology:

Breast Surgeon:

Appointment Schedule

12:45PM	Check in at the Radiation Oncology Building
1:15PM	See first provider for History & Physical appointment – no treatment related questions will be answered during this appointment
2:00PM	Provider meeting/patient break time – feel free to visit the cafeteria or coffee stand at Valley Medical Center
2:30PM	Arrive back at Radiation Oncology for afternoon appointments
2:30PM	See the provider you saw when you arrived - any treatment related questions will be answered during this appointment and successive afternoon appointments
3:00PM	See second provider
3:30PM	See third provider
4:00PM	Meet with the surgery scheduler as needed and RN care manager for coordination of care.

***** If you have questions, please call (425) 228-3440 ext 5341 and request the Nurse Navigator.***

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VALLEY
MEDICAL CENTER

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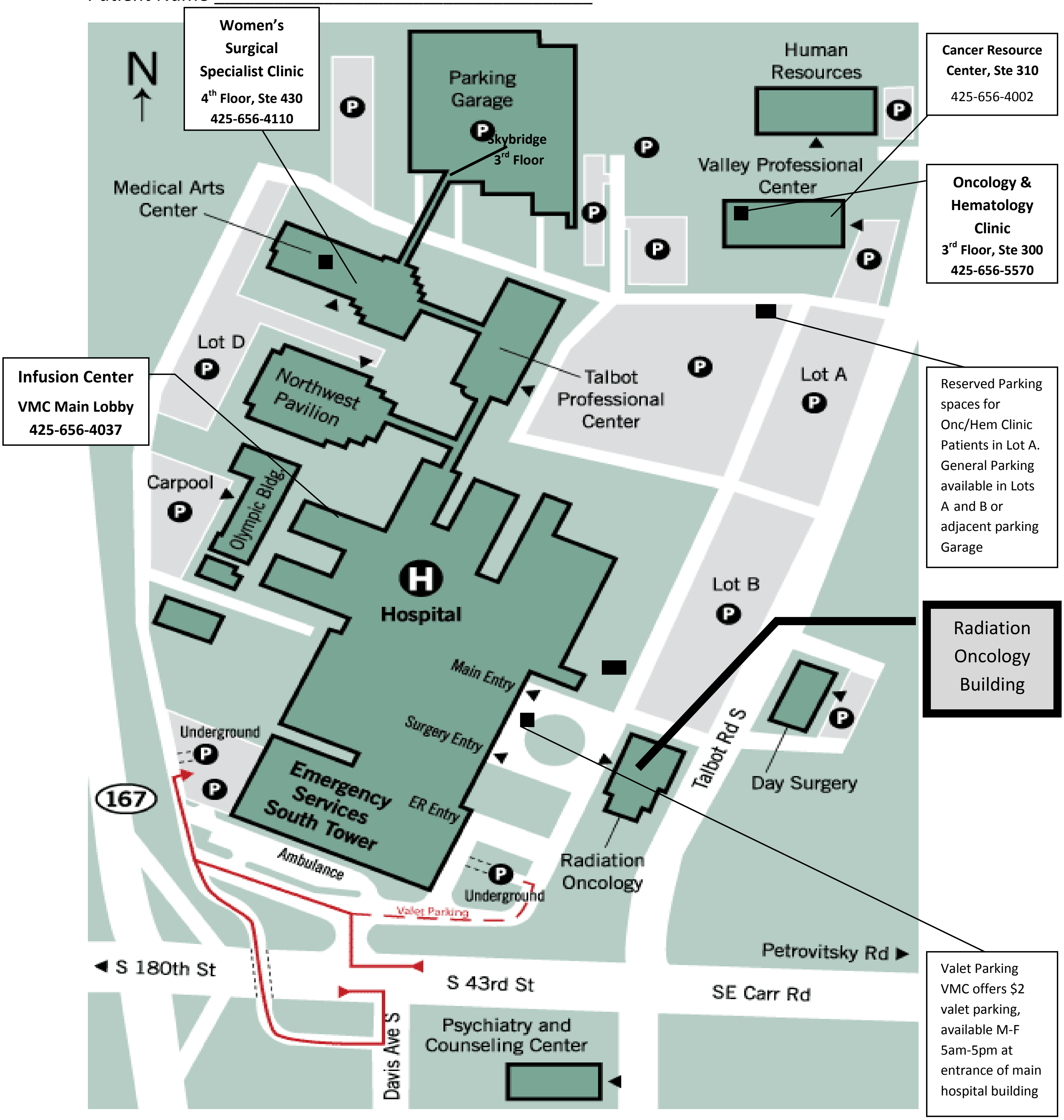

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Patient Name ___________________________________

We value your time!

In order to enhance our efficiency and avoid asking you the same questions multiple times, please fill out this form. It is essential that you **BRING THIS COMPLETED FORM WITH YOU** to your appointment at the Valley Medical Center Breast Multidisciplinary Clinic. If you need extra space, you may continue on the back of this form.

YOUR BREAST HEALTH

Do you get regular screening mammograms? YES / NO

How old were you when you started getting mammograms?

How often do you get mammograms?

Please list the dates of your last TWO mammograms:

1.

2.

Have you ever had an ***abnormal*** mammogram, breast ultrasound, or breast MRI? If yes, please describe.

Have you ever had any problems with your breasts in the past? If yes, please describe.

Have you ever had a breast biopsy? If yes, please describe the reason for the biopsy, the date of the biopsy, and the outcome.

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VALLEY
MEDICAL CENTER

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Have you had any of the following symptoms? (Please circle yes or no)

YES / NO Breast lump

YES / NO Breast pain/tenderness

YES / NO Nipple or skin changes on your breast

YES / NO Nipple discharge

How many times have you been pregnant? __________

How many times have you given birth or delivered a baby? __________

How old were you at the time of the delivery of your first child? __________

Did you breast feed your children? YES/NO

If yes, how long with each child? ____

How old were you when you had your first menstrual period? __________

Have you gone through menopause yet? YES / NO

If yes, how old were you when you started menopause? __________

If no, when was the date of your last menstrual period? _____________

Have you ever taken hormonal birth control (such as the Pill)? YES / NO

If yes, for how many years? __________

Have you ever taken hormone replacement? YES / NO

If yes, for how many years? __________

*** If YES, please stop taking your hormone replacement now***

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VALLEY
MEDICAL CENTER

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YOUR GENERAL HEALTH

Please list any ***medical conditions*** you have. This includes, previous cancers, and *any* health problems or conditions for which you see a doctor or take medication or other treatments. (Please include collagen vascular disease such as lupus, scleroderma or rheumatoid arthritis)

____

____

____

____

____

____

____

Please list any ***surgery*** you have had.

Date Procedure

____

____

____

____

____

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VALLEY MEDICAL CENTER

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Please list any previous ***radiation treatments*** you have received, the dates, and the facility where the treatments were given.

Area treated	Date	Facility

Please list the ***medications*** you take. Include any over-the-counter medications, vitamins, and herbal or other supplements.

Medication name	Dose	# times per day

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Please list any ***allergies***:

____

____

Do you use tobacco currently? YES / NO

If yes, what type? ___________________________________

For how many years have you used tobacco? _________

If you smoke cigarettes or cigars, how many do you smoke per day? ________

If you smoked in the past, when did you quit?___________

Are you ready to quit? YES / NO

Do you have a history of tobacco use? YES / NO

If yes, what type? ___________________________________

For how many years did you used tobacco? _________

If you smoked cigarettes or cigars, how many did you smoke per day? ______________________

Do you drink alcohol? YES / NO

If yes, how many times per week do you drink? _________

How many drinks do you have at a time? _________

Do you use any recreational or illegal drugs? YES / NO

If yes, what type(s)? ____

How often? ____

Do you work? YES / NO If yes, what do you do?____

Who else lives in your household with you? ____

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MEDICAL CENTER

Patient Name ___________________________________

FAMILY HEALTH HISTORY: Please tell us about the health of your family members. Please circle yes or no to the below questions that apply to YOU or YOUR FAMILY (consider both mother's and father's side).

YES / NO Diagnosis of breast Cancer under 50?

YES / NO Multiple breast cancers in one individual?

YES / NO Diagnosis of ovarian Cancer at any age?

YES / NO Male with breast cancer?

YES / NO Three (3) or more relatives on one side of the family with breast cancer?

YES / NO Breast cancer mutation in family?

YES / NO Jewish heritage with breast cancer?

YES / NO Diagnosis of colon cancer under 50?

YES / NO Diagnosis of endometrial cancer under 50?

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Please list any member of your family diagnosed with cancer in the section below. Please include the type of cancer and the age of the diagnosis. Please include any previous cancer diagnoses for yourself.

Self_________________________Sister _________________________ Brother ________________________

Father's (Paternal) Side

Great grandparents / Grandparents ____

Father : (Age)____

Uncles: (Age) ____

Aunts: (Age) ____

Cousins: (Age) ____

Nieces/Nephews: (Age) ____

Mother's (Maternal) Side

Great grandparents / Grandparents ____

Mother: (Age) ____

Uncles: (Age) ____

Aunts: (Age) ____

Cousins: (Age) ____ _______________________________

Nieces/Nephews: (Age) ____

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Do any of your relatives have *<u>other medical conditions or health problems</u>*?

Relationship to you	Medical condition
___________________________	___________________________
___________________________	___________________________
___________________________	___________________________

Have you experienced any of the following symptoms or problems recently?

YES	NO		YES	NO	
☐	☐	Fever/chills	☐	☐	Numbness/tingling
☐	☐	Fatigue	☐	☐	Stroke
☐	☐	Weakness	☐	☐	Seizures
☐	☐	Weight loss gain	☐	☐	Dizziness
☐	☐	Cough	☐	☐	Headaches
☐	☐	Shortness of breath	☐	☐	Bleeding tendency
☐	☐	Chest pain	☐	☐	Blood clots
☐	☐	Heart attack	☐	☐	Skin rash
☐	☐	Other heart problem	☐	☐	Diabetes
☐	☐	Abdominal pain	☐	☐	Thyroid problem
☐	☐	Nausea/vomiting	☐	☐	Trouble with anesthesia
☐	☐	Diarrhea	☐	☐	Recurrent infections
☐	☐	Constipation	☐	☐	Bone pain
☐	☐	Blood in your stool	☐	☐	Other _________________________
☐	☐	Trouble swallowing	☐	☐	Other _________________________
☐	☐	Heartburn	☐	☐	Other _________________________
☐	☐	Kidney disease			