



**Breast Cancer History**

Date of Breast Cancer Diagnosis: \_\_\_\_ \_\_\_\_ \_\_\_\_ Stage (if known): \_\_\_\_ Type (if known): \_\_\_\_ (e.g. DCIS, IDC)  
Month Day Year

**Surgery:**

Date(s), Type, Side of Surgery \_\_\_\_\_

Number of Lymph Nodes Removed: \_\_\_\_ Number of Positive Lymph Nodes: \_\_\_\_

**Chemotherapy:** Y\_\_N\_\_ Dates: From \_\_\_\_ \_\_\_\_ To \_\_\_\_ \_\_\_\_  
Month Year Month Year

Chemotherapy Medication(s) (if known): \_\_\_\_\_

**Radiation:** Y\_\_N\_\_ Dates: From \_\_\_\_ \_\_\_\_ To \_\_\_\_ \_\_\_\_  
Month Year Month Year

Radiated Areas (if known): \_\_\_\_\_

**Other Treatment: Please Describe:** (e.g. tamoxifen, other treatments) \_\_\_\_\_

**General Health History**

**Height:** \_\_\_\_ FT \_\_\_\_ IN. **Weight:** \_\_\_\_ Lbs. **Dominant Hand:** Right \_\_\_\_ Left \_\_\_\_

Family Physician: \_\_\_\_\_ Oncologist: \_\_\_\_\_ Surgeon: \_\_\_\_\_

Plastic Surgeon (if applicable): \_\_\_\_\_

**Current medications** (including supplements and herbal medication)

\_\_\_\_\_

**Present Medical history:**

**Please check (√) all that apply**

Heart abnormality (racing, skipping beats)

High Blood Pressure

Heart Problems

Stomach or intestinal problems

Anemia

Sleep disturbance

Migraine or frequent headaches

Dizziness

Back/Neck pain/injuries

Foot/ankle pain/injuries

**OTHER** \_\_\_\_\_

Knee/hip pain /injuries

Shoulder/arm pain/injuries

Lymphedema

High cholesterol

Diabetes

Thyroid problems

Increased anxiety/depression

Fatigue

Arthritis

Vision/hearing problems

Numbness/tingling

Please state health problems other than breast cancer (e.g. Heart, diabetes, etc.):

\_\_\_\_\_

State type and dates of previous surgery other than for breast cancer:

\_\_\_\_\_