UAMS Cancer Institute Breast Cancer Control Program Intake Form

UAMS 4301 West Markham, Slot 125 Little Rock, AR 72205 Phone 800/259-8794 Fax 501/603-1441

PATIENT INFORMATION- This information will be used when scheduling appointments and follow-up

Today's Date	Physican - (to receive results)	Physican City/State
Event County:	Event Location:	Event Date (if known):

First Name-	Last Name-	Middle-	Date of Birth-
Permanent Arkansas resident? ☐ Yes ☐ No	County	SSN-	Age:
Phone Number	Cell/Work phone	Email	
Address	City	State	Zip

Race- ☐ African American ☐ Caucasian ☐ Native American ☐ Latina ☐ Other ______________

Are you married? ☐Yes ☐No	Maiden Name-	Spouse's Name-	Phone Number-

Are you head of household? ☐ Yes ☐ No	Is the head of household employed? ☐ Yes ☐ No
Total monthly gross family income: Monthly__________	Number in household: ____

Emergency Contact	Relationship	Phone Number

INSURANCE-

☐ Not Insured	☐Medicaid	☐ Medicare	☐ Breastcare	☐ Private

Screening History

Age of first menstrual period			
Age of first live birth	Weight	Height	
Do you perform self-breast exams monthly	☐ Yes	☐ No	
ANY cancer	☐ Yes	☐ No	If yes, what kind? ___________
Breast Cancer	☐ Yes	☐ No	If yes, at what age of diagnosis? ___________
Cervical Cancer	☐ Yes	☐ No	If yes, at what age of diagnosis? ___________
Ovarian Cancer	☐ Yes	☐ No	
Hormones (hormonal replacement)	☐ Yes	☐ No	If yes, what kind? ___________ How long?
Breast Tumors	☐ Yes	☐ No	
Breast/Needle Biopsies	☐ Yes	☐ No	If yes, which breast? __________ When?
Presence of atypical hyperplasia in a breast biopsy	☐ Yes	☐ No	
Breast Cyst Aspirations	☐ Yes	☐ No	
Breast Cancer Treatment (chemo/radiation)	☐ Yes	☐ No	
Breast Implants	☐ Yes	☐ No	
Breast Reduction	☐ Yes	☐ No	
Family History of Breast Cancer	☐ Yes	☐ No	
	If yes, who and age of diagnosis? ______________________		
Family History of Cervical Cancer	☐ Yes	☐ No	
	If yes, who and age of diagnosis? ______________________		
Family History of Ovarian Cancer	☐ Yes	☐ No	If yes, who and age of diagnosis?
Hysterectomy	☐ Yes	☐ No	
	If yes, ☐ not cancer, has cervix ☐ not cancer, no cervix ☐ cancer		
Last Mammogram Facility and Date			

SYMPTOMS- Is patient currently experiencing any physical symptoms?

Lumps	☐ Yes	☐ No
Sharp pains	☐ Yes	☐ No
Nipple discharge	☐ Yes	☐ No
Inverted nipple	☐ Yes	☐ No

ANY SPECIAL NEEDS- Is patient currently experiencing any physical limitations?

Wheel Chair Usage	☐ Yes	☐ No
Trouble Standing for Mammogram	☐ Yes	☐ No