breast cancer survivorship program

Name:	**PHN:**	**Birthdate:**
Address:	City:	Postal Code:
Home Phone: Work:		Cell:
Permission to contact you for appointment reminders by text?	□ Yes □ No	
Email Address:	Permission to contact you by email?	□ Yes □ No
	□ Newsletter □ Events	
Emergency Contact & Relationship:	Emergency Contact Phone:	
Family Physician:	Occupation:	
Current Medications		
Previous Surgeries		
Drug Allergies		
Latex Allergy? □ Yes □ No	Height:	Weight:

Lifestyle

Cigarettes? □ Yes □ No Cigarettes per day? Years smoked?

Alcohol/Drinks per week? Exercise & Frequency per week?

Family History

Breast Cancer □ Yes □ No Relation:

Ovarian Cancer □ Yes □ No Relation:

Personal History

□Heart Disease	□Hypertension	□Bleeding Problems	□Migraines	□Kidney Problems
□Previous Stroke/ TIA	□Asthma/ COPD	□Thyroid Problems	□Diabetes	□Cancer
□Phlebitis	□Depression	□Other (please list)		

Have you ever been documented to be a carrier of an antibiotic resistant organism (ARO)? □ Yes □ No

Current Breast Problems:

□ Lump	□ Nipple Discharge	□ Skin Changes
□ Abnormal Mammogram	□ Pain	□ Other: _____

How long have you been aware of this change?

Date of last mammogram: Date of last ultrasound:

Previous aspirations, biopsies or breast surgeries:

Previous breast cancer (list and date please):

Age of first period: Age you were when your first child was born?

Pregnant now? □ Yes □ No Did you breast feed? □ Yes □ No If so, how many months?

On birth control pills? □ Yes □ No Ever? □ Yes □ No If yes, duration?

On hormone replacement therapy? □ Yes □ No Ever? □ Yes □ No If yes, duration?

Breast implants? □ Yes □ No

Age at menopause: □ Natural □ Surgical

Number of pregnancies: Number of children born: Ages of children:

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Breast Cancer Treatment Details

Previous breast cancer type:

Breast cancer procedure(s)	*Location*	*Date*

Did you receive chemotherapy treatment? □ Yes □ No If yes, type?

Did you receive radiotherapy treatment? □ Yes □ No If yes, where?

Current chemotherapy treatment (if applicable): □ Yes □ No

Side Effects- please check all that apply

☐ Bone pain	☐ Hot flashes	☐ Nausea	☐ Fatigue	☐ Mood swings
☐ Headache	☐ Hair thinning	☐ Dry skin	☐ Loss of libido	☐ Constipation

Date of last:

Study	*Location*	*Date*
Mammogram		
Ultrasound		
MRI		
Bone Density Scan		
Other (specify):		

Personal Assessment

Do you have adult dependents living at home? (Please describe) □ Yes □ No

Marital status: □Married □Separated □Single Spouses occupation?

Which ethnic or cultural group do you identify?

☐ Arab/ West Asian (i.e. Armenian, Iranian, Moroccan, Lebanese)	☐ Black (i.e. African, Haitian, Jamaican, Somalian)	☐ South-Eastern Asian (i.e. Thai Indonesian, Laotian, Vietnamese)
☐ South Asian (East India, Pakistan, Sri Lankan)	☐ Chinese	☐ Filipino
☐ Japanese	☐ Korean	☐ First Nations
☐ Metis	☐ Inuit	☐ Latin-American
☐ Caucasian, European	☐ Ashkenazi Jewish	☐ Other:

Which language(s) do you speak?

Are there spiritual or cultural practices you would like us to know about?

Do you have interests in the following?

☐ Meditation	☐ Reiki	☐ Aromatherapy	☐ Counselling	☐ Yoga	☐ Acupuncture

Support Network

Do you have regular contact with friends or relatives? □ Yes □ No

Have you lost your life partner within the last few years? □ Yes □ No

Can you count on anyone to provide you with emotional support? □ Yes □ No

Do you live alone? □ Yes □ No

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Physical Appearance

Do you have any concerns with your physical appearance? □ Yes □ No Describe:

Does your partner have any concerns with your physical appearance? □ Yes □ No Describe:

Are you bothered by your; lumpectomy or mastectomy scar; prosthesis; breast reconstruction? (circle one)

Are you satisfied with your hair post chemotherapy? □ Yes □ No Describe:

Post-Surgery

Have you noticed any swelling down either arm? □ Yes □ No

Do you have any issues with range of motion on the affected side? □ Yes □ No

Do you experience any pain or weakness, cramping, burning or tingling in the fingers, toes, hands or feet? □ Yes □ No

Do you experience any loss of sensation to touch? □ Yes □ No

Do you have difficulty picking up things or buttoning up clothes? □ Yes □ No

Are you more sensitive to temperatures? □ Yes □ No

Do you experience muscle weakness? □ Yes □ No

Do you notice a decrease in your reflexes? □ Yes □ No

Sexual Health - Describe:

Are you satisfied with your sexual function? □ Yes □ No (If no, please continue)

How long have you been dissatisfied with your sexual function?

Please check all that apply

☐ Little to no interest	☐ Decreased sensation	☐ Vaginal dryness
☐ Unable to climax	☐ Painful intercourse	☐ Other:

Are these concerns causing you distress? □ Yes □ No Describe:

Return to Work

Have you returned to work? □ Yes □ No If yes, how are you feeling about it?

Did you return to the same job as before? □ Yes □ No If not, would you like to?

Practical Concerns- please check all that apply

☐ Work/ School	☐ Housing	☐ Finances
☐ Transportation	☐ Dealing with kids	☐ Dealing with partner

Cardiac Toxicity

Did you receive anthracycline therapy? (i.e. Doxorubicine, Epirubicin, Daunroubicin, AC Oxorubicin + Cyclophospamide) □ Yes □ No

Do you have shortness of breath or chest pain after daily activities or exercise? □ Yes □ No

Do you have shortness of breath when lying flat, waking up at night needing to get air, or have persistent leg swelling? □ Yes □ No

Emotional: Anxiety, Depression and Distress- please check all those which apply

☐ Little interest or pleasure doing things	☐ Feeling alone	☐ Down/ depressed
☐ Frustration or anger	☐ Constant worrying	☐ Hopeless
☐ Feeling nervous or on edge	☐ Feeling a burden to others	☐ Worry about family and/or friends
☐ Other:		

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Cognitive Function

Do you have difficulties with multitasking or paying attention? □ Yes □ No

Do you have difficulties remembering things? □ Yes □ No

Does your thinking seem slow? □ Yes □ No

Fatigue

Do you feel persistent fatigue despite a good night's rest? □ Yes □ No

Does fatigue interfere with your usual activities? □ Yes □ No

How would you rate your fatigue on a scale of 0-10 (0 = not at all and 10 = constantly)

Menopause

☐ Hot flashes	☐ Night sweats	☐ Vaginal dryness
☐ Incontinence	☐ Bladder or vaginal infections	☐ Mood swings or irritability
☐ Weight gain	☐ Irregular or no menstrual periods	☐ Other:

Pain

Are you having any pain? □ Yes □ No If yes, describe:

How would you rate your pain on a scale of 0-10 (0 = not at all and 10 = constantly)

Healthy Lifestyle

Excluding white potatoes, do you eat at least 2 ½ cups of fruits and/or vegetables each day? □ Yes □ No

Do you have concerns about your weight? □ Yes □ No

Do you take multi-vitamins or supplements? □ Yes □ No If yes, which ones?

Do you have current substance use concerns? □ Yes □ No If yes, describe:

Hopes for this meeting- check all that apply

☐ Understanding long term effects of treatment	☐ Learning about available resources
☐ Finding a support group	☐ Regular clinical follow-ups

Form completed by:	☐ Patient	☐ Caregiver	☐ Intake Worker

I hereby certify that this information entered is true and correct to the best of my knowledge.

Patient Signature:_____ Date:_____

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date _____

Patient's Legal Name: _____

MSP # _____ Date of Birth: _____

Legal Guardian or power of attorney (if applicable)

Legal Name: _____

(Please provide supporting legal documents indicating relationship)

Completed by: ☐ Patient ☐ Legal Guardian or Power of Attorney

FOR OFFICE USE- staff to complete

RECORDS REQUESTED

☐ Breast Mammogram	☐ Breast Ultrasound	☐ Pathology Reports
☐ Operative Reports	☐ Consultation Reports	☐ Bone Density Scan
☐ MRI	☐ Bone Scan	☐ CT
☐ Medical Oncology: Initial Consultation Report		☐ Medical Oncology: Treatment Summary
☐ Radiation Oncology: Initial Consultation Report		☐ Radiation Oncology: Treatment Summary
☐ Current List of Medications		

NAME / COMPANY WHERE RECORDS ARE TO BE SENT

Dr. Maureen T. Leia-Stephen
Kamloops Survivorship Program
#114 – 436 Lorne Street
Kamloops, BC V2C 1W3
Phone: 250.372.9995
Fax: 250.372.7801

I, _____, or the power of attorney or legal guardian named above, hereby authorize the release of all relevant medical records pertaining to my breast cancer diagnosis and treatment to the requestor named above. Furthermore, by signing below, I acknowledge that I am responsible for the cost (if any) of this request as it is not a covered service.

_____ _____

Signature of patient or Guardian Date

_____ _____

Signature of Witness Date

_____

Witness Name (Print)