BreastCancerTrials.org
find a trial that's right for you

BreastCancerTrials.org History Form: Newly Diagnosed Breast Cancer

This form is for patients with DCIS or early stage invasive cancer who were:

- Recently diagnosed with breast cancer for the first time
- OR recently diagnosed with a recurrence or second episode of breast cancer

ABOUT ME

Year of Birth: _____

Gender:

☐ Female
☐ Male

Your menopausal status:

☐ Premenopausal

Currently pregnant:

☐ Yes
☐ No

Currently nursing:

☐ Yes
☐ No

☐ Perimenopausal

☐ Postmenopausal

Why did your menstrual cycle end?

☐ Natural menopause (absence of monthly menstrual period for 12 months or more
☐ Removal of both ovaries
☐ Radiation treatment
☐ Hormone-induced menopause
☐ Chemotherapy

Have you ever taken hormone replacement therapy for menopausal symptoms?

☐ No
☐ Yes: not currently on
☐ Yes: currently on

Have you had genetic testing for breast cancer?

☐ Yes

BRCA1: Positive Negative

BRCA2: Positive Negative

☐ No

Are you currently on a clinical trial?

☐ Yes
☐ No

MY HEALTH

Your general well-being (for past two weeks)

- ☐ I am fully active, I have no complaints or symptoms
- ☐ It takes a bit of effort to do my normal activity
- ☐ I require occasional assistance, but am able to care for most of my personal needs
- ☐ I require a large amount of assistance and frequent medical care
- ☐ I am completely disabled and am totally confined to bed or chair

Your past & current diagnoses: select all that apply

- ☐ Primary cancer other than breast cancer
  - ☐ Bone
  - ☐ Brain, spinal cord (central nervous system)
  - ☐ Cervical carcinoma, invasive
  - ☐ Cervical carcinoma, in situ
  - ☐ Colon/rectal
  - ☐ Hodgkin's disease Intestinal
  - ☐ Kidney
  - ☐ Leukemia or abnormal bone marrow cells that may lead to leukemia (myelodysplasia)
  - ☐ Lung
  - ☐ Lymphoma
  - ☐ Ovarian
  - ☐ Pancreatic
  - ☐ Prostate
  - ☐ Skin: basal or squamous cell
  - ☐ Skin: melanoma
  - ☐ Thyroid
  - ☐ Uterine
  - ☐ Other cancer: _____
- ☐ AIDS / HIV
- ☐ Anemia (severe) or blood
  - ☐ Severe anemia
  - ☐ Abnormal bleeding / clotting requiring medication
  - ☐ Other: _____
- ☐ Autoimmune (lupus, scleroderma)
  - ☐ Scleroderma
  - ☐ Systemic Lupus Erythematosus (SLE)
  - ☐ Other: _____
- ☐ Breathing or lung
  - ☐ Blood clot in lung (pulmonary embolism)
  - ☐ Chronic lung disease (COPD or emphysema)
  - ☐ Asthma requiring medication
  - ☐ Other: _____
- ☐ Digestive system (stomach, intestine, liver, colon)
  - ☐ Hepatitis B
  - ☐ Hepatitis
  - ☐ Cirrhosis
  - ☐ Other: _____
- ☐ Diabetes

(continued)

☐ Cardiovascular (heart, blood pressure)
- ☐ Chest pain (angina)
- ☐ Irregular heart beat (arrhythmia)
- ☐ Weakness of heart muscle (congestive heart failure)
- ☐ Blood clot in leg (Deep Vein Thrombosis / DVT)
- ☐ Heart attack
  Year of most recent heart attack: _____
- ☐ High blood pressure
- ☐ Other: _____

☐ Kidney, urinary or bladder
- ☐ Kidney condition: dialysis
- ☐ Kidney condition: medication, no dialysis
- ☐ Other: _____

☐ Nervous system or brain
- ☐ Damage to nerves causing numbness / pain / weakness (peripheral neuropathy)
- ☐ Blood clot to brain (stroke)
- ☐ Other: _____

☐ Osteoporosis

☐ Thyroid or other hormonal
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Other: _____

☐ Vaginal, uterine, or other reproductive organ
- ☐ Thickened lining of the uterus (endometrial hyperplasia)
- ☐ Endometriosis
- ☐ Abnormal vaginal bleeding
- ☐ Other: _____

☐ Any other health condition(s)?: _____

_____

MY DIAGNOSIS

The following questions should be answered with respect to your most recent diagnosis.

Year of most recent diagnosis: _____

Which breast was affected?

☐ Right
☐ Left
☐ Both

The questions below pertain to either the right breast or left breast

Type of diagnosis

☐ Ductal Carcinoma In situ (DCIS)
☐ Ductal carcinoma (invasive or infiltrating)
☐ Lobular carcinoma (invasive or infiltrating)

Stage at diagnosis

☐ In Situ (DCIS)
☐ Stage I
☐ Stage II
☐ Stage III
☐ Not Yet Determined

Was the cancer described as inflammatory breast cancer?

☐ No
☐ Yes
☐ I'm not sure

Tumor's Estrogen Receptor (ER) status (sometimes called "hormone receptor status")

☐ Positive
☐ Negative
☐ Unclear/Indeterminate results
☐ Not tested
☐ I'm not sure

Tumor's Progesterone Receptor (PR) status

☐ Positive
☐ Negative
☐ Unclear/Indeterminate results
☐ Not tested
☐ I'm not sure

Tumor's HER2/neu Receptor status

☐ Positive
☐ Negative
☐ Unclear/Indeterminate results
☐ Not tested
☐ I'm not sure

Tumor size, as determined by surgery

☐ Less than 2.0cm
☐ 2.1 - 5.0cm
☐ Over 5.0cm
☐ I'm not sure/I haven't had surgery yet

Was this your first diagnosis of breast cancer?

☐ Yes
☐ No

Has cancer been found in either your sentinel lymph node or other nodes of your armpit (also called axillary lymph nodes)?

☐ Yes
☐ No/not tested
☐ I'm not sure

Select all areas where cancer was found?

☐ Lymph nodes above collarbone (supraclavicular nodes)
☐ Lymph nodes below collarbone (infraclavicular nodes) Chest wall
☐ Other: _____

Have you ever been diagnosed with lymphedema?

☐ No
☐ Yes
☐ I'm not sure

Additional information: _____
_____
_____

MY TREATMENT

SURGERY

Have you ever had surgery for breast cancer or prevention?

☐ Yes
☐ No

Select all sites of past surgery:

		Month/Year
☐	**Left breast**	
☐	Lumpectomy / partial mastectomy	_____
☐	Mastectomy for diagnosed breast cancer (therapeutic)	_____
☐	Mastectomy for prevention (prophylactic)	_____
☐	Sentinel lymph node biopsy	_____
☐	Axillary node dissection	_____
☐	**Right breast**	**Month/Year**
☐	Lumpectomy / partial mastectomy	_____
☐	Mastectomy for diagnosed breast cancer (therapeutic)	_____
☐	Mastectomy for prevention (prophylactic)	_____
☐	Sentinel lymph node biopsy	_____
☐	Axillary node dissection	_____
☐	**Ovaries**	**Month/Year**
☐	Left ovary (oophorectomy)	_____
☐	Right ovary (oophorectomy)	_____
☐	Hysterectomy (including oophorectomy)	_____

RADIATION THERAPY

Have you had radiation therapy for breast cancer?

☐ Yes

Breast	**Start Date (Month/Year)**
☐ Left breast	_____
☐ Right breast	_____

☐ No

Have you ever received radiation for any of the following?

☐ Hodgkin's disease
☐ Thyroid disease
☐ Lung disease
☐ Other/I'm not sure: _____

CHEMOTHERAPY

Select all chemotherapy treatments received:

☐ Abraxane®/Carboplatin
☐ Abraxane®/Xeloda®
☐ AC (Adriamycin®/Cytoxan®)
☐ AC followed by Taxol® (Adriamycin®/Cytoxan®/Taxol®)
☐ AC followed by Taxotere® (Adriamycin®/Cytoxan/Taxotere®)
☐ CMF (Cytoxan®/Methotrexate/5-Fluorouracil)

(continued)

☐ FAC/CAF (5-Fluorouracil/Adriamycin®/Cytoxan®) FEC (Fluorouracil/Epirubicin/Cytoxan®)
☐ Halaven®
☐ Ixempra®
☐ Ixempra®/Xeloda®
☐ TC (Taxotere®/Cytoxan®)
☐ TAC (Taxotere®/Adriamycin®/Cytoxan®) Taxol®/Xeloda®
☐ Taxotere®/Xeloda® Taxol®/Gemzar® Taxotere®/Carboplatin
☐ Taxol®/Carboplatin
☐ Other: _____

Follow-up questions for chemotherapy treatment:
(Additional copies of follow-up questions are found at the end of this form)

Name of treatment: _____
Start date (Year; include month if in the last 12 months): _____

This treatment was received
☐ Between diagnosis and surgery
☐ After surgery

Are you currently on this treatment?
☐ Yes
☐ No: Completed treatment regimen
Treatment end date ((Year; include month if in the last 12 months): _____
☐ No: Discontinued treatment before completing regimen

Why did you stop treatment?
☐ Tumor occurred, recurred, or did not shrink with therapy
☐ Stopped treatment due to side-effects of therapy
☐ I'm not sure/Other

TARGETED/BIOLOGICAL THERAPY

Select ALL targeted/biological therapies taken (alone or in combination with chemotherapy):
Herceptin®/Trastuzumab
Tykerb®/Lapatinib
Avastin®/Bevacizumab

Follow-up questions for biological/targeted therapy:
(Additional copies of follow-up questions are found at the end of this form)

Name of treatment: _____
Start date (Year; include month if in the last 12 months): _____

This treatment was received
☐ Between diagnosis and surgery
☐ After surgery

Are you currently on this treatment?
☐ Yes
☐ No: Completed treatment regimen
Treatment end date ((Year; include month if in the last 12 months): _____
☐ No: Discontinued treatment before completing regimen

Why did you stop treatment?
☐ Tumor occurred, recurred, or did not shrink with therapy
☐ Stopped treatment due to side-effects of therapy
☐ I'm not sure/Other

ENDOCRINE/HORMONE THERAPY

Select all endocrine/hormone therapy received:

Anti-Estrogen Drugs

- ☐ Evista®/Raloxifene
- ☐ Fareston®/Toremifine
- ☐ Faslodex®/Fulvestrant
- ☐ Nolvadex®/Tamoxifen

Aromatase Inhibitors

- ☐ Arimidex®/Anastrozole
- ☐ Aromasin®/Exemestane
- ☐ Femara®/Letrozole

Ovarian Suppression

- ☐ Lupron®/Leuprolide
- ☐ Plenaxis®/Abarelix
- ☐ Suprefact®/Buserelin
- ☐ Zoladex®/Goserelin

Other Endocrine/HT

- ☐ Megace®/Megestrol Acetate

Follow-up questions for Endocrine/Hormone Therapy:

(Additional copies of follow-up questions are found at the end of this form)

Name of treatment: _____

Start date (Year; include month if in the last 12 months): _____

This treatment was received

☐ Before diagnosis of primary breast cancer
☐ Between diagnosis and surgery
☐ After surgery

Are you currently on this treatment?

☐ Yes
☐ No: Completed treatment regimen
Treatment end date ((Year; include month if in the last 12 months): _____
☐ No: Discontinued treatment before completing regimen

Why did you stop treatment?

- ☐ Tumor occurred, recurred, or did not shrink with therapy
- ☐ Stopped treatment due to side-effects of therapy
- ☐ I'm not sure/Other

BISPHOSPONATE OR OTHER THERAPY TO INCREASE BONE DENSITY OR STRENGTH

Select ALL medications received:

☐ Actonel®/Risedronate
☐ Aredia®/Pamidronate
☐ Boniva®/Ibandronate
☐ Fosamex®/Alendronate
☐ Zometa®/Zoledronate

Follow-up questions for Bisphosphonate Therapy:

(Additional copies of follow-up questions are found at the end of this form)

Name of treatment: _____

Start date (Year; include month if in the last 12 months): _____

This treatment was received for

☐ Bone density loss prior to treatment

☐ Bone density loss related to treatment

Are you currently on this treatment?

☐ Yes

☐ No: Completed treatment regimen

Treatment end date (Year; include month if in the last 12 months): _____

☐ No: Discontinued treatment before completing regimen

Why did you stop treatment?

☐ Tumor occurred, recurred, or did not shrink with therapy

☐ Stopped treatment due to side-effects of therapy

☐ I'm not sure/Other

ADDITIONAL INFORMATION

The information you provide in this section is voluntary, and will be used to help improve future service. For more information regarding the safety and privacy of information you provide us, please visit our Privacy Policy.

Highest level of completed schooling:

☐ Less than high school

☐ High school graduate / GED

☐ Some college or technical school

☐ College graduate

☐ Postgraduate education

What is your racial background?

☐ American Indian or Alaska Native

☐ Asian

☐ Black or African American

☐ Hispanic or Latino

☐ Native Hawaiian or Other Pacific Islander

☐ White

☐ Other

Are you of Latino / Hispanic heritage?

☐ No

☐ Yes

How did you hear about BreastCancerTrials.org (this website)?

☐ Doctor / nurse / medical team

☐ Another patient

☐ Breast cancer support group

☐ Friend or family member

☐ Internet: Name of search engine or web site: _____

☐ Local or national organization

☐ Name of organization:

☐ Radio announcement

☐ Other: _____

Additional forms for Treatment Follow-up Questions

Chemotherapy treatment:

Name of treatment: _____
Start date (Year; include month if in the last 12 months): _____

This treatment was received
☐ Between diagnosis and surgery
☐ After surgery

Are you currently on this treatment?
☐ Yes
☐ No: Completed treatment regimen
Treatment end date ((Year; include month if in the last 12 months): _____
☐ No: Discontinued treatment before completing regimen

Why did you stop treatment?
☐ Tumor occurred, recurred, or did not shrink with therapy
☐ Stopped treatment due to side-effects of therapy
☐ I'm not sure/Other

Name of treatment: _____
Start date (Year; include month if in the last 12 months): _____

This treatment was received
☐ Between diagnosis and surgery
☐ After surgery

Are you currently on this treatment?
☐ Yes
☐ No: Completed treatment regimen
Treatment end date ((Year; include month if in the last 12 months): _____
☐ No: Discontinued treatment before completing regimen

Why did you stop treatment?
☐ Tumor occurred, recurred, or did not shrink with therapy
☐ Stopped treatment due to side-effects of therapy
☐ I'm not sure/Other

Name of treatment: _____
Start date (Year; include month if in the last 12 months): _____

This treatment was received
☐ Between diagnosis and surgery
☐ After surgery

Are you currently on this treatment?
☐ Yes
☐ No: Completed treatment regimen
Treatment end date ((Year; include month if in the last 12 months): _____
☐ No: Discontinued treatment before completing regimen

Why did you stop treatment?
☐ Tumor occurred, recurred, or did not shrink with therapy
☐ Stopped treatment due to side-effects of therapy
☐ I'm not sure/Other

Biological/targeted therapy:

Name of treatment: _____

Start date (Year; include month if in the last 12 months): _____

This treatment was received

☐ Between diagnosis and surgery

☐ After surgery

Are you currently on this treatment?

☐ Yes

☐ No: Completed treatment regimen

Treatment end date ((Year; include month if in the last 12 months): _____

☐ No: Discontinued treatment before completing regimen

Why did you stop treatment?

☐ Tumor occurred, recurred, or did not shrink with therapy

☐ Stopped treatment due to side-effects of therapy

☐ I'm not sure/Other

Endocrine/Hormone Therapy:

Name of treatment: _____

Start date (Year; include month if in the last 12 months): _____

This treatment was received

☐ Before diagnosis of primary breast cancer

☐ Between diagnosis and surgery

☐ After surgery

Are you currently on this treatment?

☐ Yes

☐ No: Completed treatment regimen

Treatment end date ((Year; include month if in the last 12 months): _____

☐ No: Discontinued treatment before completing regimen

Why did you stop treatment?

☐ Tumor occurred, recurred, or did not shrink with therapy

☐ Stopped treatment due to side-effects of therapy

☐ I'm not sure/Other

Bisphosphonate Therapy:

Name of treatment: _____

Start date (Year; include month if in the last 12 months): _____

This treatment was received for

☐ Bone density loss prior to treatment

☐ Bone density loss related to treatment

Are you currently on this treatment?

☐ Yes

☐ No: Completed treatment regimen

Treatment end date (Year; include month if in the last 12 months): _____

☐ No: Discontinued treatment before completing regimen

Why did you stop treatment?

☐ Tumor occurred, recurred, or did not shrink with therapy

☐ Stopped treatment due to side-effects of therapy

☐ I'm not sure/Other

Name of treatment: _____

Start date (Year; include month if in the last 12 months): _____

This treatment was received for

☐ Bone density loss prior to treatment

☐ Bone density loss related to treatment

Are you currently on this treatment?

☐ Yes

☐ No: Completed treatment regimen

Treatment end date (Year; include month if in the last 12 months): _____

☐ No: Discontinued treatment before completing regimen

Why did you stop treatment?

☐ Tumor occurred, recurred, or did not shrink with therapy

☐ Stopped treatment due to side-effects of therapy

☐ I'm not sure/Other