聖路加国際病院
St. Luke's International Hospital

Breast Center Questionnaire

This Questionnaire contains important information for the medical care you receive at this hospital. Please answer in detail, independent of the content of the reference letter.

Age	years	Date	MM DD , YYYY

Do you undergo breast cancer checkups regularly? ☐YES ☐NO ☐Other ( )
If you answered YES: From the age of ____years, every ____years; ☐Mammography ☐Ultrasound ☐Alternating ☐Only Palpation

How did you find the present abnormality? ☐Breast cancer check-up ☐Subjective symptoms ☐Other ( )

Tests undergone at another hospital:
☐Mammography ☐Ultrasound ☐MRI ☐Cyst Aspiration ☐Needle Biopsy ☐Surgery ☐Other

Subjective Symptoms ☐Absent ☐Present (☐Lump ☐Pain (No pain:0 1 2 3 4 5 6 7 8 9 10:Worst possible pain) ☐Nipple Discharge ☐Others ( )

Have you received a diagnosis of definite/suspected breast cancer at another medical institution? ☐YES ☐NO

Are you currently receiving treatment for breast cancer at another medical institution? ☐YES ☐NO

Please describe the course of your current breast problem in detail.

Contact: Phone no.: ( ) — ☐Home ☐Mobile (☐Your own ☐Someone else( )) ☐Work ☐Other( )
Another phone no.: ( ) — ☐Home ☐Mobile (☐Your own ☐Someone else( )) ☐Work ☐Other( )
Can we leave a message from the hospital with your family? ☐YES ☐NO
Please give us an address where we can send you letters, including your test results, from the Breast Center.

Address:

If you have an appointment within the next 3 months, we will return the X-ray films, CD-R, etc. from the other medical institution to you at the that time.
If you do not have a scheduled appointment, can we send these to your home? ☐YES ☐NO
If you have answered NO, we will return these materials to the medical institution that referred you. If these do not have to be returned, we will responsibly dispose of them at this hospital.

Medical History	**Please fill out the following information concerning diseases you experienced and surgical operations you underwent.**		
Hypertension	☐NO	☐YES: ☐Under treatment ☐Treatment terminated	
Diabetes	☐NO	☐YES: ☐Under treatment ☐Treatment terminated	Insulin usage: ☐NO ☐YES
Asthma	☐NO	☐YES: ☐Under treatment (Last attack: M Y)	
Glaucoma	☐NO	☐YES: ☐Under treatment ☐Treatment terminated	
Others	(Age: years) ( ); (Age: years) ( )		
	(Age: years) ( ); (Age: years) ( )		
History of Psychosomatic Medicine consultations	☐NO ☐YES (Age years:)	History of taking sleeping pills/anti-anxiety agents	☐NO ☐YES (Age years:)
Negative feelings	Mark the number representing the average extent of negative feelings you experienced over the last week with a circle (○).	No negative feelings:0 1 2 3 4 5 6 7 8 9 10: Extreme negative feelings	
	To what extent did your negative feelings interfere with your daily life activities?	No interference:0 1 2 3 4 5 6 7 8 9 10: Severe interference	
Allergies	☐NO	☐YES:☐Medications ( ) ☐Metal ( ) ☐Others ( )	
Surgery	☐NO	☐YES (Age years:); (Age years:)	
Smoking	☐NO	☐YES ( ) cigarettes/day for ( ) years ; ( ) years since quitting	
Alcohol	☐NO	☐YES ( ) amount / day; type: ( ) for ( ) years; ( ) years since quitting	
Covid-19 vaccinations	□NO	□YES	Last vaccination (MM DD , YY) / (Left / Right)
Influenza vaccination	□NO	□YES	(MM DD , YY) / (Left / Right)

Please also fill out the back.

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Gynecology History

Menstruation	First menstruation (age: years); Period:☐Regular ☐Irregular ☐Menopause (years) ☐Artificial menopause (years)		
	First day of last menstrual cycle: M D , Y	Menstruation cycle: days	
Pregnancy/Delivery	Pregnancy:	Delivery: times	☐Pregnant now: weeks days ☐May be pregnant
Gynecological Diseases	☐NO	☐YES ☐Uterine myoma (Surgery: ☐NO ☐YES, procedure:) ☐Endometriosis ☐Ovarian cyst (Surgery: ☐NO ☐YES, procedure:) ☐Other: (Surgery: ☐NO ☐YES, procedure:)	
Breastfeeding History	☐NO	☐Currently breastfeeding ☐YES	
Infertility Treatment	☐NO	☐YES (When?: /Which?: How many times?:)	

History of hormone replacement therapy: ☐NO ☐YES (When? /What? /How long?:)

Oral medications/Supplements **Please list all medications you are currently taking, and bring your Medication Notebook along.**

☐NO ☐YES: Name(s) of the drug(s):

Family History (Blood relatives, up to cousins on both the father's and mother' sides)
Include age at the time of onset of the disease and therapy

■ **Breast/Ovarian cancer** ☐Yes ☐No

Siblings/Children:

Mother, maternal relatives:

Father, paternal relatives:

Other kinds of cancer ☐Yes ☐No

■ Siblings/Children:

Mother, maternal relatives:

Father, paternal relatives:

Other diseases than cancer ☐Yes ☐No

■ Siblings/Children:

Mother, maternal relatives:

Father, paternal relatives:

Family structure

Spouse ☐Yes: years Occupation:
☐Widowed ☐Unmarried ☐Divorced

Partner ☐Yes ☐No

Own father: years ☐Died ☐Lives together ☐Lives separately

Own mother years ☐Died ☐Lives together ☐Lives separately

Children (Age/Living together or not)

Own siblings (Age/Living together or not)

People providing support to you:

Occupation **We support you with your work and career while you undergo treatment. Please ask the staff for more information.**

Employment ☐ Unemployed ☐ Employed Field of work:

Employment Status ☐ Freelance ☐ Full-time ☐ Contract Employee ☐ Part-time

Specific Job Description:

You can have a consultation about employment matters. Do you wish to have such a consultation? ☐YES ☐NO

Do you have a boss or industrial physician at work whom you trust and can consult with? ☐ YES ☐ NO ☐ I'm not sure

Working arrangements: Nighttime shifts ☐YES ☐NO Flex-time/reduced schedule ☐YES ☐NO Business Trips ☐YES ☐NO

Off days: days /week on ( )day / ( )day/( )day Holiday system ☐YES ☐NO

Others

Many patients who have children find it hard to explain their disease to their children. At St. Luke's International Hospital, a child support team is available to advise you. Do you wish to have a consultation with the child support team? ☐YES ☐NO

For those considering pregnancy/delivery, we offer treatment in collaboration with the Integrated Women's Health Clinic
Do you wish to have a consultation at the Integrated Women's Health Clinic? ☐YES ☐NO

At this hospital, patients are treated with blood transfusion when deemed medically necessary.
Do you agree to undergo blood transfusion in the event that it becomes medically necessary? ☐YES ☐NO

【For patients over 65 years】 Have you applied for long-term care insurance?
☐Yes, I applied: Require assistance ( ); Require nursing care ( ); ☐Under application (When?); ☐Not applied; ☐Unsure

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