＜Medical Questionnaire＞

Name:	Age: years old
Date:	Patient Registration ID:

■**PLEASE fill in ALL PAGES BEFORE YOUR APPOINTMENT.** Your answer will help the staff plan and provide your care, as well as help us with our research to better understand the risk factors for cancer. Leave blank any parts you are unsure of, or do not wish to answer. We will review the form with you. Any information we gather will be kept confidential.

Do you have regular breast cancer checkups? ☐ YES ☐ NO
If you answered YES: From _____(year), every _____ years Other information ( )

Reason for visit ☐Breast cancer checkup ☐Subjective symptoms ☐Other ( )

Examinations received at other medical institution: ☐MMG ☐Echo ☐MRI ☐Cytodiagnosis ☐Needle Biopsy ☐Surgery ☐Other( )

Subjective Symptoms ☐NONE ☐YES (☐Lump ☐Pain ☐Nipple Discharge ☐Other ( )

Have you been diagnosed/suspected of 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 illness

■Phone no.: (　　) ー ☐Home ☐Cell phone [☐Patient ☐Other(　　)] ☐Work ☐Other( )

■Spare phone no.: (　　) ー ☐Home ☐Cell phone [☐Patient ☐Other(　　)]☐Work ☐Other( )

■Can we leave a message to your family from the hospital? ☐YES ☐NO

■Please give us an address where we can send messages from the breast center.

P.O

■If you have an appointment within the next 3 months, the X-ray film you have brought from another medical institution will be returned to you directly.

If you For those who do not have another appointment booked, would you like them to be sent to your home? ☐YES ☐NO
If you answered NO, it will be returned to the hospital you have been referred from. If you do not want it returned, the hospital will responsibly dispose them.

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Medical History	Please fill in information on your past medical history, etc.		
High blood pressure	☐NONE	☐YES : ☐Under treatment ☐Treatment terminated	
Diabetes	☐NONE	☐YES : ☐Under treatment ☐Treatment terminated	Insulin Usage ☐NONE ☐YES
Asthma	☐NONE	☐YES : ☐Under treatment	
Glaucoma	☐NONE	☐YES : ☐Under treatment ☐Treatment terminated	
Allergies	☐NONE	☐YES( ): ☐Under treatment	
Surgery	☐NONE	☐YES(, Age:) (, Age:)	
Smoking	☐NONE	☐YES ( )cigarettes/day ( )years /( )years since quitting	
Alcohol	☐NONE	☐YES Amount( ) ( )years /( )years since quitting	
Other	(Age:) (Age:)		
	(Age:) (Age:)		
Gynecological History	☐Married ☐Unmarried(Partner ☐YES ☐NONE) ☐Divorced(Partner ☐YES ☐NONE) ☐Widowed		
Menstruation	First menstruation (age): Period: ☐ Regular ☐ Irregular ☐ Menopause (age): ☐ Artificial menopause(age):		
	The first day of the last menstrual period (Year: Month: Date:)	Menstruation cycle (days)	
Pregnancy/Delivery	Pregnancy: times	Delivery: times	☐ Pregnant: months ☐ Possibly pregnant
Gynecological Diseases	☐NONE	☐YES ☐Myoma of the uterus (Surgery ☐NONE ☐YES Procedure: ☐Endometriosis ☐Ovarian Cyst (Surgery ☐NONE ☐YES Procedure:) ☐Other ( ) (Surgery ☐NONE ☐YES Procedure)	
Feeding History	☐NONE ☐Currently breastfeeding ☐YES		
Infertility Treatment	☐NONE ☐YES (Period/Frequency)		
Hormone Replacement Therapy History ☐NONE ☐YES (Period/Span)			

Medication/Supplements	Please indicate all the medication you currently take, and when you started taking them.
☐NONE ☐YES	

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Family History	Please fill in the information of your blood relatives（Paternal and maternal, up to cousins）

History of cancer is especially important when considering cancer heredity. It may alter treatment methods.
If you have concerns about cancer inheritance, please let us know ahead of time. (Genetic tests take 1 month until the results come back.)
If available, please indicate the approximate age when your relative received diagnosis, and what kind of treatment he/she received.
* Mammary fibroadenoma, ovarian cyst, myoma of the uterus, and endometriosis are not cancer.

■ **Breast Cancer/Ovarian Cancer**

Siblings /Children:

Maternal relatives:

Paternal relatives:

■ **Other Cancers**

Siblings /Children:

Maternal relatives:

Paternal relatives:

■ **Diseases other than Cancer**

Siblings /Children:

Maternal relatives:

Paternal relatives:

Occupation	We also hope to support your working stylecareer during treatment. Please ask the staff for more information.

Employment ☐ Unemployed ☐ Employed

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

Specific Job Description:

Do you have a boss or industrial physician that you can trust and talk to? ☐ YES ☐ NO ☐ I'm NOT sure

Working arrangements: Nighttime shifts ☐NONE ☐YES Flex-time/reduced schedule ☐NONE ☐YES
Business Trips ☐NONE ☐YES

Holidays (day of the week) Holiday System ☐NONE ☐YES

The diagnosis and treatment of breast cancer may cause significant anxiety. At our facility, the psycho-oncology physician cares for patients who wish for support. Do you wish for advice? ☐YES ☐NO

Many find it difficult to talk about their diagnosis to their children.
At our facility, a child life specialist can give advice. Do you wish for adviseadvice? ☐YES ☐NO

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

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