

The Breast Cancer Consultation Service
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In order to expedite the review (second opinion) of your breast cancer diagnosis, we are asking for your cooperation in providing us information essential for the evaluation of your case. Please be as complete as you can. Leave the spaces blank if you have not undergone a particular procedure or treatment. Please tell us if any of these tests are under a different surname than the one you use at present. **PLEASE NOTE: Since we often experience up to a two week delay in receiving requested diagnostic materials from hospitals, if you are interested in expediting this review, we ask that you please call pathology/radiology departments and urge them to send us the materials we have requested as quickly as possible.**

Patient Name: _____

1. When was a problem first noted in your breast? _____ (month/year)

Was the abnormality detected by: yourself a physician/nurse a mammogram ultrasound, MRI

2. Mammogram History	<i>Date</i>	<i>Hospital</i>	<i>Hospital Address</i>	<i>Phone/Fax</i>
Most recent Mammogram/US				
Prior Mammogram/US				
Breast MRI				

3. **Procedure History:** Please use the spaces below to list all the diagnostic tests and surgical procedures which led to your diagnosis.

	<i>Date</i>	<i>Hospital</i>	<i>Hospital Address</i>	<i>Phone/Fax</i>	<i>Physician</i>
Fine Needle Aspiration (FNA)					
Stereotactic or other Core Biopsy					
Open Biopsy/Needle Localization					
Lumpectomy/Partial Mastectomy					
Axillary Nodes or Sentinel Node Dissection					
Mastectomy					
Reconstruction					

4. Please indicate if you have currently begun or completed Radiation Therapy Chemotherapy, and/or Tamoxifen

5. Treatment History:

	<i>Date</i>	<i>Hospital</i>	<i>Hospital Address</i>	<i>Phone/Fax</i>	<i>Physician</i>
Tamoxifen					
Radiation Therapy					
Chemotherapy					
Any Experimental Protocol					

6. Family History: Please tell us about your family history of any cancer, but most particularly breast, ovarian, uterine (endometrial), colon and brain cancers. Please note the approximate age of the relative when the diagnosis was made.

<i>Relationship</i>	<i>Age at Diagnosis</i>	<i>Type of Cancer</i>
<i>Example: Mother</i>	<i>66</i>	<i>Uterine</i>

7. Personal History:

Are you currently on hormone (estrogen) replacement therapy? Yes No
 Have you recently terminated hormone replacement therapy? Yes No
 Are you: menstruating regularly menstruating irregularly post menopausal
 Have you: had a hysterectomy had your ovaries removed

8. Very Important. Please tell us in your own words what your concerns are and what questions in particular you would like to have addressed. Please be as detailed as possible; continue on another sheet if necessary. _____
