



# Sister Study Breast Cancer Medical Report Form

Patient Name: \_\_\_\_\_

Date of Birth:   /   /      
*mm/dd/yyyy*

Date this form completed:   /   /      
*mm/dd/yyyy*

Doctor(s) and Address: *(please print)*

Doctor's Name: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_

Affiliation: \_\_\_\_\_

Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Who completed this form? *(please print)*

Name: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_

**INSTRUCTIONS:** Please provide a copy of the breast cancer medical reports listed below and check the corresponding box. Also, please fill in as much of the attached form as possible. Please return the medical reports and/or this form within the next **30 days** using the enclosed addressed envelope. Thank you!

*Have you enclosed a copy of the following medical reports?*

- |  |                          |                          |  |
|--|--------------------------|--------------------------|--|
| Please provide or correct pathologist information below. | Yes                      | No                       |  |
|  | <input type="checkbox"/> | <input type="checkbox"/> | (1) Pathology report from the breast biopsy;                   |
|  | <input type="checkbox"/> | <input type="checkbox"/> | (2) Pathology report from the lumpectomy/mastectomy;           |
|  | <input type="checkbox"/> | <input type="checkbox"/> | (3) Pathology report from the lymph node dissection;           |
|  | <input type="checkbox"/> | <input type="checkbox"/> | (4) Estrogen and progesterone receptor assay report;           |
|  | <input type="checkbox"/> | <input type="checkbox"/> | (5) Narrative discharge summary for the relevant admission(s); |
|  | <input type="checkbox"/> | <input type="checkbox"/> | (6) HER2NEU test results;                                      |
|  | <input type="checkbox"/> | <input type="checkbox"/> | (7) Treatment Plan and/or summary;                             |
|  | <input type="checkbox"/> | <input type="checkbox"/> | (8) Other relevant records.                                    |

Name of Pathologist(s)/Lab: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_

Name of Pathologist(s)/Lab: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_

Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

<b>For Office Use Only:</b>	SIS ID #: _____	Source: _____
	<input type="checkbox"/> Validation	<input type="checkbox"/> Data Retrieval

1. Date of breast cancer diagnosis: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mm/dd/yyyy

2. Weight prior to surgery and treatment: Pounds: \_\_\_\_\_  
Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mm/dd/yyyy

3. Total number of tumors: \_\_\_\_\_

**Instructions:** Please complete one column of the Tumor Characteristics grid for each individual tumor per breast cancer diagnosis. If there was one tumor - complete column one only, two tumors - complete two columns only, and so forth.

Tumor Characteristic	Tumor 1	Tumor 2	Tumor 3
4. Pathology accession number(s)	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____
5. Type	<input type="checkbox"/> Invasive: _____% <input type="checkbox"/> In situ: _____% <input type="checkbox"/> Not documented	<input type="checkbox"/> Invasive: _____% <input type="checkbox"/> In situ: _____% <input type="checkbox"/> Not documented	<input type="checkbox"/> Invasive: _____% <input type="checkbox"/> In situ: _____% <input type="checkbox"/> Not documented
6. Invasive tumor size (single longest dimension in cm)	_____ . _____ cm	_____ . _____ cm	_____ . _____ cm
7. In situ tumor size (single longest dimension in cm)	_____ . _____ cm	_____ . _____ cm	_____ . _____ cm
8. Multifocal tumor	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not documented	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not documented	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not documented
9. Location	<input type="checkbox"/> Ductal <input type="checkbox"/> Lobular <input type="checkbox"/> Mixed—ductal dominant <input type="checkbox"/> Mixed—lobular dominant <input type="checkbox"/> No primary location evident <input type="checkbox"/> Not documented	<input type="checkbox"/> Ductal <input type="checkbox"/> Lobular <input type="checkbox"/> Mixed—ductal dominant <input type="checkbox"/> Mixed—lobular dominant <input type="checkbox"/> No primary location evident <input type="checkbox"/> Not documented	<input type="checkbox"/> Ductal <input type="checkbox"/> Lobular <input type="checkbox"/> Mixed—ductal dominant <input type="checkbox"/> Mixed—lobular dominant <input type="checkbox"/> No primary location evident <input type="checkbox"/> Not documented
10. Laterality	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Not documented	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Not documented	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Not documented

Tumor 4	Tumor 5	Tumor 6
_____	_____	_____
_____	_____	_____
_____	_____	_____
<input type="checkbox"/> Invasive: _____% <input type="checkbox"/> In situ: _____% <input type="checkbox"/> Not documented	<input type="checkbox"/> Invasive: _____% <input type="checkbox"/> In situ: _____% <input type="checkbox"/> Not documented	<input type="checkbox"/> Invasive: _____% <input type="checkbox"/> In situ: _____% <input type="checkbox"/> Not documented
_____ . _____ cm	_____ . _____ cm	_____ . _____ cm
_____ . _____ cm	_____ . _____ cm	_____ . _____ cm
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not documented	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not documented	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not documented
<input type="checkbox"/> Ductal <input type="checkbox"/> Lobular <input type="checkbox"/> Mixed—ductal dominant <input type="checkbox"/> Mixed—lobular dominant <input type="checkbox"/> No primary location evident <input type="checkbox"/> Not documented	<input type="checkbox"/> Ductal <input type="checkbox"/> Lobular <input type="checkbox"/> Mixed—ductal dominant <input type="checkbox"/> Mixed—lobular dominant <input type="checkbox"/> No primary location evident <input type="checkbox"/> Not documented	<input type="checkbox"/> Ductal <input type="checkbox"/> Lobular <input type="checkbox"/> Mixed—ductal dominant <input type="checkbox"/> Mixed—lobular dominant <input type="checkbox"/> No primary location evident <input type="checkbox"/> Not documented
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Not documented	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Not documented	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Not documented

Tumor Characteristic	Tumor 1	Tumor 2	Tumor 3
11. Quadrant location	<input type="checkbox"/> Upper outer quadrant <input type="checkbox"/> Lower outer quadrant <input type="checkbox"/> Upper inner quadrant <input type="checkbox"/> Lower inner quadrant <input type="checkbox"/> Central <input type="checkbox"/> Nipple <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented	<input type="checkbox"/> Upper outer quadrant <input type="checkbox"/> Lower outer quadrant <input type="checkbox"/> Upper inner quadrant <input type="checkbox"/> Lower inner quadrant <input type="checkbox"/> Central <input type="checkbox"/> Nipple <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented	<input type="checkbox"/> Upper outer quadrant <input type="checkbox"/> Lower outer quadrant <input type="checkbox"/> Upper inner quadrant <input type="checkbox"/> Lower inner quadrant <input type="checkbox"/> Central <input type="checkbox"/> Nipple <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented
12. Evidence of Lymphatic-Vascular Invasion (LVI)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain <input type="checkbox"/> Not documented	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain <input type="checkbox"/> Not documented	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain <input type="checkbox"/> Not documented
13. Method of determination of tumor size	<input type="checkbox"/> Pathology <input type="checkbox"/> Mammography <input type="checkbox"/> Clinically <input type="checkbox"/> Not documented	<input type="checkbox"/> Pathology <input type="checkbox"/> Mammography <input type="checkbox"/> Clinically <input type="checkbox"/> Not documented	<input type="checkbox"/> Pathology <input type="checkbox"/> Mammography <input type="checkbox"/> Clinically <input type="checkbox"/> Not documented
14. Tumor histology - invasive ductal only	<input type="checkbox"/> Invasive ductal NOS <input type="checkbox"/> Invasive ductal with lobular tendencies <input type="checkbox"/> Cribriform <input type="checkbox"/> Inflammatory <input type="checkbox"/> Medullary <input type="checkbox"/> Micropapillary <input type="checkbox"/> Mucinous <input type="checkbox"/> Necrosis <input type="checkbox"/> Papillary <input type="checkbox"/> Tubular <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented	<input type="checkbox"/> Invasive ductal NOS <input type="checkbox"/> Invasive ductal with lobular tendencies <input type="checkbox"/> Cribriform <input type="checkbox"/> Inflammatory <input type="checkbox"/> Medullary <input type="checkbox"/> Micropapillary <input type="checkbox"/> Mucinous <input type="checkbox"/> Necrosis <input type="checkbox"/> Papillary <input type="checkbox"/> Tubular <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented	<input type="checkbox"/> Invasive ductal NOS <input type="checkbox"/> Invasive ductal with lobular tendencies <input type="checkbox"/> Cribriform <input type="checkbox"/> Inflammatory <input type="checkbox"/> Medullary <input type="checkbox"/> Micropapillary <input type="checkbox"/> Mucinous <input type="checkbox"/> Necrosis <input type="checkbox"/> Papillary <input type="checkbox"/> Tubular <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented
15. Tumor histology - In situ ductal only	<input type="checkbox"/> Micropapillary <input type="checkbox"/> Papillary <input type="checkbox"/> Cribriform <input type="checkbox"/> Solid <input type="checkbox"/> Comedonecrosis <input type="checkbox"/> Necrosis <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented	<input type="checkbox"/> Micropapillary <input type="checkbox"/> Papillary <input type="checkbox"/> Cribriform <input type="checkbox"/> Solid <input type="checkbox"/> Comedonecrosis <input type="checkbox"/> Necrosis <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented	<input type="checkbox"/> Micropapillary <input type="checkbox"/> Papillary <input type="checkbox"/> Cribriform <input type="checkbox"/> Solid <input type="checkbox"/> Comedonecrosis <input type="checkbox"/> Necrosis <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented
16. Tumor histology - lobular	<input type="checkbox"/> Invasive lobular NOS <input type="checkbox"/> Invasive lobular classic <input type="checkbox"/> Invasive lobular pleomorphic <input type="checkbox"/> Invasive lobular with ductal tendencies <input type="checkbox"/> Necrosis <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented	<input type="checkbox"/> Invasive lobular NOS <input type="checkbox"/> Invasive lobular classic <input type="checkbox"/> Invasive lobular pleomorphic <input type="checkbox"/> Invasive lobular with ductal tendencies <input type="checkbox"/> Necrosis <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented	<input type="checkbox"/> Invasive lobular NOS <input type="checkbox"/> Invasive lobular classic <input type="checkbox"/> Invasive lobular pleomorphic <input type="checkbox"/> Invasive lobular with ductal tendencies <input type="checkbox"/> Necrosis <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented

Tumor 4	Tumor 5	Tumor 6
<input type="checkbox"/> Upper outer quadrant <input type="checkbox"/> Lower outer quadrant <input type="checkbox"/> Upper inner quadrant <input type="checkbox"/> Lower inner quadrant <input type="checkbox"/> Central <input type="checkbox"/> Nipple <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented	<input type="checkbox"/> Upper outer quadrant <input type="checkbox"/> Lower outer quadrant <input type="checkbox"/> Upper inner quadrant <input type="checkbox"/> Lower inner quadrant <input type="checkbox"/> Central <input type="checkbox"/> Nipple <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented	<input type="checkbox"/> Upper outer quadrant <input type="checkbox"/> Lower outer quadrant <input type="checkbox"/> Upper inner quadrant <input type="checkbox"/> Lower inner quadrant <input type="checkbox"/> Central <input type="checkbox"/> Nipple <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain <input type="checkbox"/> Not documented	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain <input type="checkbox"/> Not documented	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain <input type="checkbox"/> Not documented
<input type="checkbox"/> Pathology <input type="checkbox"/> Mammography <input type="checkbox"/> Clinically <input type="checkbox"/> Not documented	<input type="checkbox"/> Pathology <input type="checkbox"/> Mammography <input type="checkbox"/> Clinically <input type="checkbox"/> Not documented	<input type="checkbox"/> Pathology <input type="checkbox"/> Mammography <input type="checkbox"/> Clinically <input type="checkbox"/> Not documented
<input type="checkbox"/> Invasive ductal NOS <input type="checkbox"/> Invasive ductal with lobular tendencies <input type="checkbox"/> Cribriform <input type="checkbox"/> Inflammatory <input type="checkbox"/> Medullary <input type="checkbox"/> Micropapillary <input type="checkbox"/> Mucinous <input type="checkbox"/> Necrosis <input type="checkbox"/> Papillary <input type="checkbox"/> Tubular <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented	<input type="checkbox"/> Invasive ductal NOS <input type="checkbox"/> Invasive ductal with lobular tendencies <input type="checkbox"/> Cribriform <input type="checkbox"/> Inflammatory <input type="checkbox"/> Medullary <input type="checkbox"/> Micropapillary <input type="checkbox"/> Mucinous <input type="checkbox"/> Necrosis <input type="checkbox"/> Papillary <input type="checkbox"/> Tubular <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented	<input type="checkbox"/> Invasive ductal NOS <input type="checkbox"/> Invasive ductal with lobular tendencies <input type="checkbox"/> Cribriform <input type="checkbox"/> Inflammatory <input type="checkbox"/> Medullary <input type="checkbox"/> Micropapillary <input type="checkbox"/> Mucinous <input type="checkbox"/> Necrosis <input type="checkbox"/> Papillary <input type="checkbox"/> Tubular <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented
<input type="checkbox"/> Micropapillary <input type="checkbox"/> Papillary <input type="checkbox"/> Cribriform <input type="checkbox"/> Solid <input type="checkbox"/> Comedonecrosis <input type="checkbox"/> Necrosis <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented	<input type="checkbox"/> Micropapillary <input type="checkbox"/> Papillary <input type="checkbox"/> Cribriform <input type="checkbox"/> Solid <input type="checkbox"/> Comedonecrosis <input type="checkbox"/> Necrosis <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented	<input type="checkbox"/> Micropapillary <input type="checkbox"/> Papillary <input type="checkbox"/> Cribriform <input type="checkbox"/> Solid <input type="checkbox"/> Comedonecrosis <input type="checkbox"/> Necrosis <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented
<input type="checkbox"/> Invasive lobular NOS <input type="checkbox"/> Invasive lobular classic <input type="checkbox"/> Invasive lobular pleomorphic <input type="checkbox"/> Invasive lobular with ductal tendencies <input type="checkbox"/> Necrosis <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented	<input type="checkbox"/> Invasive lobular NOS <input type="checkbox"/> Invasive lobular classic <input type="checkbox"/> Invasive lobular pleomorphic <input type="checkbox"/> Invasive lobular with ductal tendencies <input type="checkbox"/> Necrosis <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented	<input type="checkbox"/> Invasive lobular NOS <input type="checkbox"/> Invasive lobular classic <input type="checkbox"/> Invasive lobular pleomorphic <input type="checkbox"/> Invasive lobular with ductal tendencies <input type="checkbox"/> Necrosis <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented

Tumor Characteristic	Tumor 1	Tumor 2	Tumor 3
17. Invasive grade (see list below)	Overall grade _____ Nuclear grade _____ Tubular grade _____ Mitotic grade _____	Overall grade _____ Nuclear grade _____ Tubular grade _____ Mitotic grade _____	Overall grade _____ Nuclear grade _____ Tubular grade _____ Mitotic grade _____
18. In situ grade (see list below)	Nuclear grade _____	Nuclear grade _____	Nuclear grade _____
19. Estrogen Receptor Assay (ERA) type	<input type="checkbox"/> Biochemical <input type="checkbox"/> Immunohistochemical (ERICA) <input type="checkbox"/> Immunofluorescent <input type="checkbox"/> Nucleic acid amplification (eg RT-PCR) <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented	<input type="checkbox"/> Biochemical <input type="checkbox"/> Immunohistochemical (ERICA) <input type="checkbox"/> Immunofluorescent <input type="checkbox"/> Nucleic acid amplification (eg RT-PCR) <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented	<input type="checkbox"/> Biochemical <input type="checkbox"/> Immunohistochemical (ERICA) <input type="checkbox"/> Immunofluorescent <input type="checkbox"/> Nucleic acid amplification (eg RT-PCR) <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented
20. Estrogen Receptor Assay (ERA) results	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Borderline/marginal <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Borderline/marginal <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Borderline/marginal <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented
21. ERA value	ERA value: _____	ERA value: _____	ERA value: _____
22. Progesterone Receptor Assay (PRA) type	<input type="checkbox"/> Biochemical <input type="checkbox"/> Immunohistochemical (ERICA) <input type="checkbox"/> Immunofluorescent <input type="checkbox"/> Nucleic acid amplification (eg RT-PCR) <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented	<input type="checkbox"/> Biochemical <input type="checkbox"/> Immunohistochemical (ERICA) <input type="checkbox"/> Immunofluorescent <input type="checkbox"/> Nucleic acid amplification (eg RT-PCR) <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented	<input type="checkbox"/> Biochemical <input type="checkbox"/> Immunohistochemical (ERICA) <input type="checkbox"/> Immunofluorescent <input type="checkbox"/> Nucleic acid amplification (eg RT-PCR) <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented
23. Progesterone Receptor Assay (PRA) results	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Borderline/marginal <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Borderline/marginal <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Borderline/marginal <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented

### GRADING SCALE FOR QUESTIONS 17 & 18

- 1 = predominately well-differentiated
- 2 = moderately differentiated/balanced pattern
- 3 = poorly differentiated
- ND = not documented

Tumor 4	Tumor 5	Tumor 6
Overall grade _____ Nuclear grade _____ Tubular grade _____ Mitotic grade _____	Overall grade _____ Nuclear grade _____ Tubular grade _____ Mitotic grade _____	Overall grade _____ Nuclear grade _____ Tubular grade _____ Mitotic grade _____
Nuclear grade _____	Nuclear grade _____	Nuclear grade _____
<input type="checkbox"/> Biochemical <input type="checkbox"/> Immunohistochemical (ERICA) <input type="checkbox"/> Immunofluorescent <input type="checkbox"/> Nucleic acid amplification (eg RT-PCR) <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented	<input type="checkbox"/> Biochemical <input type="checkbox"/> Immunohistochemical (ERICA) <input type="checkbox"/> Immunofluorescent <input type="checkbox"/> Nucleic acid amplification (eg RT-PCR) <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented	<input type="checkbox"/> Biochemical <input type="checkbox"/> Immunohistochemical (ERICA) <input type="checkbox"/> Immunofluorescent <input type="checkbox"/> Nucleic acid amplification (eg RT-PCR) <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented
<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Borderline/marginal <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Borderline/marginal <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Borderline/marginal <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented
ERA value: _____	ERA value: _____	ERA value: _____
<input type="checkbox"/> Biochemical <input type="checkbox"/> Immunohistochemical (ERICA) <input type="checkbox"/> Immunofluorescent <input type="checkbox"/> Nucleic acid amplification (eg RT-PCR) <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented	<input type="checkbox"/> Biochemical <input type="checkbox"/> Immunohistochemical (ERICA) <input type="checkbox"/> Immunofluorescent <input type="checkbox"/> Nucleic acid amplification (eg RT-PCR) <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented	<input type="checkbox"/> Biochemical <input type="checkbox"/> Immunohistochemical (ERICA) <input type="checkbox"/> Immunofluorescent <input type="checkbox"/> Nucleic acid amplification (eg RT-PCR) <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented
<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Borderline/marginal <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Borderline/marginal <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Borderline/marginal <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented

Tumor Characteristic	Tumor 1	Tumor 2	Tumor 3
24. PRA value	PRA value: _____	PRA value: _____	PRA value: _____
25. HER-2/NEU assay type	<input type="checkbox"/> Immunohistochemistry (IHC) <input type="checkbox"/> FISH, gene amplification <input type="checkbox"/> Both IHC and FISH <input type="checkbox"/> Other, specify: _____  <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented	<input type="checkbox"/> Immunohistochemistry (IHC) <input type="checkbox"/> FISH, gene amplification <input type="checkbox"/> Both IHC and FISH <input type="checkbox"/> Other, specify: _____  <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented	<input type="checkbox"/> Immunohistochemistry (IHC) <input type="checkbox"/> FISH, gene amplification <input type="checkbox"/> Both IHC and FISH <input type="checkbox"/> Other, specify: _____  <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented
26. HER-2/NEU value (IHC only)	<input type="checkbox"/> 0 <input type="checkbox"/> +1 <input type="checkbox"/> +2 <input type="checkbox"/> +3 <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> 0 <input type="checkbox"/> +1 <input type="checkbox"/> +2 <input type="checkbox"/> +3 <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> 0 <input type="checkbox"/> +1 <input type="checkbox"/> +2 <input type="checkbox"/> +3 <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented
27. HER-2/NEU value (FISH)	FISH value: _____	FISH value: _____	FISH value: _____
28. Results of HER-2/NEU	<input type="checkbox"/> Overexpressed <input type="checkbox"/> Not overexpressed <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Overexpressed <input type="checkbox"/> Not overexpressed <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Overexpressed <input type="checkbox"/> Not overexpressed <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented
29. DNA ploidy	<input type="checkbox"/> Diploid/Euploid/Normal (DNA Index 1.0) <input type="checkbox"/> Aneuploid/Abnormal (DNA Index>1.0) <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Diploid/Euploid/Normal (DNA Index 1.0) <input type="checkbox"/> Aneuploid/Abnormal (DNA Index>1.0) <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Diploid/Euploid/Normal (DNA Index 1.0) <input type="checkbox"/> Aneuploid/Abnormal (DNA Index>1.0) <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented
30. S-phase	<input type="checkbox"/> Low (or < reference) <input type="checkbox"/> Intermediate <input type="checkbox"/> High (or > reference) <input type="checkbox"/> Equivocal <input type="checkbox"/> Specify percentage: _____% <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Low (or < reference) <input type="checkbox"/> Intermediate <input type="checkbox"/> High (or > reference) <input type="checkbox"/> Equivocal <input type="checkbox"/> Specify percentage: _____% <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Low (or < reference) <input type="checkbox"/> Intermediate <input type="checkbox"/> High (or > reference) <input type="checkbox"/> Equivocal <input type="checkbox"/> Specify percentage: _____% <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented

Tumor 4	Tumor 5	Tumor 6
PRA value: _____	PRA value: _____	PRA value: _____
<input type="checkbox"/> Immunohistochemistry (IHC) <input type="checkbox"/> FISH, gene amplification <input type="checkbox"/> Both IHC and FISH <input type="checkbox"/> Other, specify: _____  <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented	<input type="checkbox"/> Immunohistochemistry (IHC) <input type="checkbox"/> FISH, gene amplification <input type="checkbox"/> Both IHC and FISH <input type="checkbox"/> Other, specify: _____  <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented	<input type="checkbox"/> Immunohistochemistry (IHC) <input type="checkbox"/> FISH, gene amplification <input type="checkbox"/> Both IHC and FISH <input type="checkbox"/> Other, specify: _____  <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented
<input type="checkbox"/> 0 <input type="checkbox"/> +1 <input type="checkbox"/> +2 <input type="checkbox"/> +3 <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> 0 <input type="checkbox"/> +1 <input type="checkbox"/> +2 <input type="checkbox"/> +3 <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> 0 <input type="checkbox"/> +1 <input type="checkbox"/> +2 <input type="checkbox"/> +3 <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented
FISH value: _____	FISH value: _____	FISH value: _____
<input type="checkbox"/> Overexpressed <input type="checkbox"/> Not overexpressed <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Overexpressed <input type="checkbox"/> Not overexpressed <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Overexpressed <input type="checkbox"/> Not overexpressed <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented
<input type="checkbox"/> Diploid/Euploid/Normal (DNA Index 1.0) <input type="checkbox"/> Aneuploid/Abnormal (DNA Index>1.0) <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Diploid/Euploid/Normal (DNA Index 1.0) <input type="checkbox"/> Aneuploid/Abnormal (DNA Index>1.0) <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Diploid/Euploid/Normal (DNA Index 1.0) <input type="checkbox"/> Aneuploid/Abnormal (DNA Index>1.0) <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented
<input type="checkbox"/> Low (or < reference) <input type="checkbox"/> Intermediate <input type="checkbox"/> High (or > reference) <input type="checkbox"/> Equivocal <input type="checkbox"/> Specify percentage: _____% <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Low (or < reference) <input type="checkbox"/> Intermediate <input type="checkbox"/> High (or > reference) <input type="checkbox"/> Equivocal <input type="checkbox"/> Specify percentage: _____% <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Low (or < reference) <input type="checkbox"/> Intermediate <input type="checkbox"/> High (or > reference) <input type="checkbox"/> Equivocal <input type="checkbox"/> Specify percentage: _____% <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented

**Surgical Treatment** (complete all that apply)

	Left Breast	Right Breast
31. Date of <b>FIRST</b> post-diagnosis surgery	____/____/____ mm/dd/yyyy	____/____/____ mm/dd/yyyy
32. Type of surgery	<input type="checkbox"/> Lumpectomy <input type="checkbox"/> Other Breast Conserving Therapy (BCT) <input type="checkbox"/> Mastectomy <input type="checkbox"/> No post-diagnosis surgery performed <input type="checkbox"/> Not documented	<input type="checkbox"/> Lumpectomy <input type="checkbox"/> Other Breast Conserving Therapy (BCT) <input type="checkbox"/> Mastectomy <input type="checkbox"/> No post-diagnosis surgery performed <input type="checkbox"/> Not documented

	Left Breast	Right Breast
33. Date of <b>SECOND</b> post-diagnosis surgery	____/____/____ mm/dd/yyyy	____/____/____ mm/dd/yyyy
34. Type of surgery	<input type="checkbox"/> Lumpectomy <input type="checkbox"/> Other Breast Conserving Therapy (BCT) <input type="checkbox"/> Mastectomy <input type="checkbox"/> No post-diagnosis surgery performed <input type="checkbox"/> Not documented	<input type="checkbox"/> Lumpectomy <input type="checkbox"/> Other Breast Conserving Therapy (BCT) <input type="checkbox"/> Mastectomy <input type="checkbox"/> No post-diagnosis surgery performed <input type="checkbox"/> Not documented

	Left Breast	Right Breast
35. Date of <b>THIRD</b> post-diagnosis surgery	____/____/____ mm/dd/yyyy	____/____/____ mm/dd/yyyy
36. Type of surgery	<input type="checkbox"/> Lumpectomy <input type="checkbox"/> Other Breast Conserving Therapy (BCT) <input type="checkbox"/> Mastectomy <input type="checkbox"/> No post-diagnosis surgery performed <input type="checkbox"/> Not documented	<input type="checkbox"/> Lumpectomy <input type="checkbox"/> Other Breast Conserving Therapy (BCT) <input type="checkbox"/> Mastectomy <input type="checkbox"/> No post-diagnosis surgery performed <input type="checkbox"/> Not documented

37. Closest final margin	<input type="checkbox"/> Positive <input type="checkbox"/> Negative If Negative, Specify Size: ____ . ____ cm
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## Lymph Node Involvement and Metastatic Results

### 38. Lymph node involvement (Sentinel lymph node biopsy and final surgery combined)

Number sampled: \_\_\_\_\_

Number malignant: \_\_\_\_\_

### 39. Results of metastatic work up:

- Completely negative
- Incomplete or equivocal
- Metastatic at diagnosis

- Work up not performed
- Not documented

### 40. If metastatic, which distal sites were affected:

- Bone
- Brain
- Liver
- Lung

- Other  
Specify: \_\_\_\_\_

- Not documented

## Chemotherapy Treatment

41. Neo-adjuvant (pre-surgery) chemotherapy for breast cancer:  Yes  
 No  
 Not documented

42. If yes,

Chemotherapy Regimen (see list below)	# Cycles	Mark if therapy on-going	Start date mm/dd/yyyy	End date mm/dd/yyyy (if known)	Prescribed dosing interval
<i>Example: ATC</i>	<i>2</i>	<input type="checkbox"/>	<i>02/01/2006</i>	<i>02/15/2006</i>	<i>q 2 weeks</i>
		<input type="checkbox"/>			
		<input type="checkbox"/>			

43. Adjuvant chemotherapy for breast cancer:  Yes  
 No  
 Not documented

44. If yes,

Chemotherapy Regimen (see list below)	# Cycles	Mark if therapy on-going	Start date mm/dd/yyyy	End date mm/dd/yyyy (if known)	Prescribed dosing interval
<i>Example: CMF</i>	<i>4</i>	<input checked="" type="checkbox"/>	<i>03/01/2006</i>		<i>q 2 weeks</i>
		<input type="checkbox"/>			
		<input type="checkbox"/>			
		<input type="checkbox"/>			
		<input type="checkbox"/>			
		<input type="checkbox"/>			

### LIST OF CHEMOTHERAPY REGIMENS FOR QUESTIONS 42 & 44:

Abraxane	FEC/CEF—Fluorouracil/Epirubicin/Cytosin
Avastin	MF—Methotrexate/Fluorouracil
A—Adriamycin (only)	Navelbine
AC—Adriamycin/Cytosin	T—Taxol
ACZ—Adriamycin/Cytosin/Zinecard	TC—Taxol/Carboplatin
AT—Adriamycin/Taxol	Td—Taxotere
ATC—Adriamycin/Taxol or Taxotere/Cytosin	TdAC—Taxotere/Adriamycin/Carboplatin
CMF—Cytosin/Methotrexate/Fluorouracil	T+H—Taxol plus Herceptin
CAF/FAC—Cytosin/Adriamycin/Fluorouracil	Xeloda
EC - Epirubicin/Cytosin	Other—please specify

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## Biological Therapy

45. Herceptin treatment or other biological treatment for breast cancer?  Yes  
 No  
 Not documented

46. If yes,

*(If dose changed, enter on a separate line)*

Drug Name	Mark if therapy on-going	Start date mm/dd/yyyy	End date mm/dd/yyyy (if known)	Dosage
	<input type="checkbox"/>			

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## Hormonal Treatment

47. Hormonal treatments such as tamoxifen, raloxifene, or aromatase inhibitors [Arimidex (Anastrozole), Femara (Letrozole), Aromasin (Exemestane)], Faslodex, or Megace]?  Yes  
 No  
 Not documented

48. If yes,

*(If dose changed, enter on a separate line)*

Drug Name	Mark if therapy on-going	Start date mm/dd/yyyy	End date mm/dd/yyyy (if known)	Dosage
	<input type="checkbox"/>			

## Radiation Treatment

49. Radiation therapy:  Yes  
 No  
 Not documented

50. If yes,

Target Site of Radiation Treatment	Left Breast				Right Breast			
	Mark if therapy on-going	Start date mm/dd/yyyy	End date mm/dd/yyyy (if known)	Cumulative Dose (cGy)	Mark if therapy on-going	Start date mm/dd/yyyy	End date mm/dd/yyyy (if known)	Cumulative Dose (cGy)
Whole Breast	<input type="checkbox"/>	____/____/____	____/____/____		<input type="checkbox"/>	____/____/____	____/____/____	
Tumor Bed	<input type="checkbox"/>	____/____/____	____/____/____		<input type="checkbox"/>	____/____/____	____/____/____	
Chest Wall	<input type="checkbox"/>	____/____/____	____/____/____		<input type="checkbox"/>	____/____/____	____/____/____	
Supraclavicular (SCV)	<input type="checkbox"/>	____/____/____	____/____/____		<input type="checkbox"/>	____/____/____	____/____/____	
Axilla	<input type="checkbox"/>	____/____/____	____/____/____		<input type="checkbox"/>	____/____/____	____/____/____	
Intramammary nodes (IMN)	<input type="checkbox"/>	____/____/____	____/____/____		<input type="checkbox"/>	____/____/____	____/____/____	

51. Internal radiation technique used:  Yes, specify type: \_\_\_\_\_  
 No  
 Not documented

## Clinical Trial Enrollment

52. Enrolled in a clinical trial for breast cancer treatment/management:  Yes  
 No  
 Not documented

53. If yes,

Name or ID number of trial: \_\_\_\_\_

Treatment(s) or procedure(s) tested: \_\_\_\_\_

Treatment(s) or procedure(s) patient received as part of the trial (if known): \_\_\_\_\_

Sponsor of trial (e.g. NIH, CALGB): \_\_\_\_\_

54. Did patient complete the trial?:  Completed  Did not complete, dropped out  
 Ongoing  Not documented

## Treatment Toxicity

55. Treatment toxicity side effects present:  Yes  
 No  
 Not documented

56. If yes, treatment toxicity side effects:  Allergic reaction  Neuropathy  
 Anemia  Thrombocytopenia  
 Clinical cardiotoxicity  Other  
 Gastrointestinal Specify: \_\_\_\_\_  
 Myalgia  
 Neutropenia

## Genetic Testing

57. BRCA1 Genetic testing:  Positive Specify Variant: \_\_\_\_\_  Negative  
 Equivocal Specify Variant: \_\_\_\_\_  Test not done  
 Not documented

58. BRCA2 Genetic testing:  Positive Specify Variant: \_\_\_\_\_  Negative  
 Equivocal Specify Variant: \_\_\_\_\_  Test not done  
 Not documented

## Other Molecular Profiling

59. Molecular Profiling and Proliferation assay:  Yes  
 No  
 Not documented

60. If yes,

Assay Type	Score
Ki-67	
E-cadherin	
OncotypeDX	
p53	
p63	
Other, specify: _____	
Other, specify: _____	

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Please check to see that all questions are answered.

**Thank you for completing this form and for  
your help with the Sister Study.**

Please mail this form to us at the address below.

A postage-paid envelope is provided.

The Sister Study, 1009 Slater Road, Suite 120, Durham, NC 27703  
phone: 1-877-4SISTER (1-877-474-7837); email: [info@sisterstudy.org](mailto:info@sisterstudy.org)

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