



Sister Study Breast Cancer Master File Cover Sheet for Medical Report Form



SIS ID:

Date of Diagnosis: / /
mm dd yyyy

Report Changes

- New Report
- Attached with additions
- Attached with changes
- No additions or changes

Report Status

- Interim
- Final
- Refused

Last Date on Medical Records/Pathology Report: / /
mm dd yyyy

Origin (1=HCP, 2=Woman):

Record Type (1=Medical Records, 2=Pathology Report, 3=Both):

Point of Contact (1=Oncologist, 2=Surgeon, 3=Radiologist, 4=Pathologist, 5=Other):

Cancer Type (6=Breast Cancer):

Date of Abstraction: / /
mm dd yyyy

Completed Sections:

- | | | |
|---|---|--|
| <input type="checkbox"/> 1. Tumor Characteristics and Surgery | <input type="checkbox"/> 4. Biological Treatment | <input type="checkbox"/> 8. Treatment Side Effects |
| <input type="checkbox"/> 2. Lymph Node Involvement and Metastatic Results | <input type="checkbox"/> 5. Hormonal Treatment | <input type="checkbox"/> 9. Genetic Testing |
| <input type="checkbox"/> 3. Chemotherapy Treatment | <input type="checkbox"/> 6. Radiation Treatment | <input type="checkbox"/> 10. Other Molecular Profiling |
| | <input type="checkbox"/> 7. Clinical Trial Enrollment | <input type="checkbox"/> 11. ALL RECORDED |

Validation

Data Retrieval



Sister Study Breast Cancer Medical Report Form



Date of Birth: / /
mm dd yyyy

Who completed this form? (please print name) _____

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"/> | (a) Pathology report from the breast biopsy; |
| | <input type="checkbox"/> | <input type="checkbox"/> | (b) Pathology report from the lumpectomy/mastectomy; |
| | <input type="checkbox"/> | <input type="checkbox"/> | (c) Pathology report from the lymph node dissection; |
| | <input type="checkbox"/> | <input type="checkbox"/> | (d) Estrogen and progesterone receptor assay report; |
| | <input type="checkbox"/> | <input type="checkbox"/> | (e) Narrative discharge summary for the relevant admission(s); |
| | <input type="checkbox"/> | <input type="checkbox"/> | (f) HER2NEU test results; |
| | <input type="checkbox"/> | <input type="checkbox"/> | (g) Treatment Plan and/or summary; |
| | <input type="checkbox"/> | <input type="checkbox"/> | (h) Other relevant records. |

Name of Pathology Facility #1: _____

Phone: () _____

Address: _____

City/Town: _____ State: _____ Zip: _____

Name of Pathology Facility #2: _____

Phone: () _____

Address: _____

City/Town: _____ State: _____ Zip: _____

2. Weight prior to surgery and treatment (if n/a, use closest date available): Pounds: _____

Date:

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 /

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 /

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mm *dd* *yyyy*

3. Total number of tumors: _____

Tumor Characteristic	Tumor 1		Tumor 2		Tumor 3	
4. Pathology accession number(s)	ACCESSION # _____ _____ _____	PATHOLOGY # _____ _____ _____	ACCESSION # _____ _____ _____	PATHOLOGY # _____ _____ _____	ACCESSION # _____ _____ _____	PATHOLOGY # _____ _____ _____
5. Type (MARK ALL THAT APPLY)	<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	
7a. 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	
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"/> Mixed—equal ductal and lobular <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"/> Mixed—equal ductal and lobular <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"/> Mixed—equal ductal and lobular <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 Characteristic	Tumor 1	Tumor 2	Tumor 3
11. Quadrant location (MARK ALL THAT APPLY)	<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"/> Multicentric <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"/> Multicentric <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"/> Multicentric <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
13x. LCIS present	<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
14. Tumor histology - invasive ductal only (MARK ALL THAT APPLY)	<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"/> Apocrine <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"/> Apocrine <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"/> Apocrine <input type="checkbox"/> Not documented
15. Tumor histology - In situ ductal only (MARK ALL THAT APPLY)	<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 (MARK ALL THAT APPLY)	<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	Overall grade _____ Tubular grade _____ Nuclear grade _____ Mitotic grade _____	Overall grade _____ Tubular grade _____ Nuclear grade _____ Mitotic grade _____	Overall grade _____ Tubular grade _____ Nuclear grade _____ Mitotic grade _____
18. In situ grade	Nuclear grade _____	Nuclear grade _____	Nuclear grade _____
19. Estrogen Receptor Assay (ERA) type (MARK ALL THAT APPLY)	<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 (% IHC)	ERA value: _____	ERA value: _____	ERA value: _____
22. Progesterone Receptor Assay (PRA) type (MARK ALL THAT APPLY)	<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
24. PRA value (% IHC)	PRA value: _____	PRA value: _____	PRA value: _____

Tumor Characteristic	Tumor 1	Tumor 2	Tumor 3
25. HER-2/NEU assay type (MARK ALL THAT APPLY)	<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"/> Equivocal <input type="checkbox"/> Not documented	<input type="checkbox"/> Overexpressed <input type="checkbox"/> Not overexpressed <input type="checkbox"/> Test not done <input type="checkbox"/> Equivocal <input type="checkbox"/> Not documented	<input type="checkbox"/> Overexpressed <input type="checkbox"/> Not overexpressed <input type="checkbox"/> Test not done <input type="checkbox"/> Equivocal <input type="checkbox"/> Not documented
29. DNA ploidy	<input type="checkbox"/> Diploid/Euploid/Normal (DNA Index 1.1) <input type="checkbox"/> Aneuploid/Abnormal (DNA Index>1.1) <input type="checkbox"/> Test not done <input type="checkbox"/> Hypodiploid <input type="checkbox"/> Not documented	<input type="checkbox"/> Diploid/Euploid/Normal (DNA Index 1.1) <input type="checkbox"/> Aneuploid/Abnormal (DNA Index>1.1) <input type="checkbox"/> Test not done <input type="checkbox"/> Hypodiploid <input type="checkbox"/> Not documented	<input type="checkbox"/> Diploid/Euploid/Normal (DNA Index 1.1) <input type="checkbox"/> Aneuploid/Abnormal (DNA Index>1.1) <input type="checkbox"/> Test not done <input type="checkbox"/> Hypodiploid <input type="checkbox"/> Not documented
30. S-phase (MARK ALL THAT APPLY)	<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 FIRST 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"/> Re-excision <input type="checkbox"/> Biopsy (entire tumor removed) <input type="checkbox"/> Not documented	<input type="checkbox"/> Lumpectomy <input type="checkbox"/> Other Breast Conserving Therapy (BCT) <input type="checkbox"/> Mastectomy <input type="checkbox"/> Re-excision <input type="checkbox"/> Biopsy (entire tumor removed) <input type="checkbox"/> Not documented
	Left Breast	Right Breast
33. Date of SECOND 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"/> Re-excision <input type="checkbox"/> Not documented	<input type="checkbox"/> Lumpectomy <input type="checkbox"/> Other Breast Conserving Therapy (BCT) <input type="checkbox"/> Mastectomy <input type="checkbox"/> Re-excision <input type="checkbox"/> Not documented
	Left Breast	Right Breast
35. Date of THIRD 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"/> Re-excision <input type="checkbox"/> Not documented	<input type="checkbox"/> Lumpectomy <input type="checkbox"/> Other Breast Conserving Therapy (BCT) <input type="checkbox"/> Mastectomy <input type="checkbox"/> Re-excision <input type="checkbox"/> Not documented
	Left Breast	Right Breast
36x1. Date of FOURTH post-diagnosis surgery	____/____/____ mm dd yyyy	____/____/____ mm dd yyyy
36x2. Type of surgery	<input type="checkbox"/> Lumpectomy <input type="checkbox"/> Other Breast Conserving Therapy (BCT) <input type="checkbox"/> Mastectomy <input type="checkbox"/> Re-excision <input type="checkbox"/> Not documented	<input type="checkbox"/> Lumpectomy <input type="checkbox"/> Other Breast Conserving Therapy (BCT) <input type="checkbox"/> Mastectomy <input type="checkbox"/> Re-excision <input type="checkbox"/> Not documented

37. Closest final margin Positive Negative
If Negative, Specify Size: _____ cm

37a. Tumor found in last surgery Yes No Not documented

Lymph Node Involvement and Metastatic Results

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

a. Number sampled: _____

b. Number malignant: _____

c. Node staging: _____

39a. Results of metastatic work up at diagnosis: Completely negative Incomplete or equivocal Metastatic at diagnosis Work up not performed Not documented

39b. If metastatic at diagnosis, which distal sites were affected: Bone Brain Liver Lung Other Specify: _____ Not documented

40a. Results of metastatic work up post diagnosis: Completely negative Incomplete or equivocal Metastatic post diagnosis Work up not performed Not documented

40b. If metastatic post diagnosis, which distal sites were affected: Bone Brain Liver Lung Other Specify: _____ Not documented

40c. Date of metastatic workup post diagnosis:

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mm dd yyyy

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
		<input type="checkbox"/>			
		<input type="checkbox"/>			
		<input type="checkbox"/>			
		<input type="checkbox"/>			
		<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
		<input type="checkbox"/>			
		<input type="checkbox"/>			
		<input type="checkbox"/>			
		<input type="checkbox"/>			
		<input type="checkbox"/>			
		<input type="checkbox"/>			
		<input type="checkbox"/>			

- 44x. Other Chemotherapy regimen (non-cytotoxic) Yes
 No
 Not documented

If yes,

Other Chemotherapy Regimen (non-cytotoxic)	# Cycles	Mark if therapy on-going	Start date mm/dd/yyyy	End date mm/dd/yyyy (if known)	Prescribed dosing interval
		<input type="checkbox"/>			
		<input type="checkbox"/>			
		<input type="checkbox"/>			

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	# Cycles	Mark if therapy on-going	Start date mm/dd/yyyy	End date mm/dd/yyyy (if known)	Prescribed Dosing Interval
		<input type="checkbox"/>			
		<input type="checkbox"/>			
		<input type="checkbox"/>			
		<input type="checkbox"/>			

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	Pre DX
	<input type="checkbox"/>				<input type="checkbox"/>
	<input type="checkbox"/>				<input type="checkbox"/>
	<input type="checkbox"/>				<input type="checkbox"/>
	<input type="checkbox"/>				<input type="checkbox"/>

Radiation Treatment

49. Radiation therapy: Yes
 No
 Not documented

50. If yes - External Radiation:

Left Breast					Right Breast			
Target Site of Radiation Treatment	Mark if therapy on-going	Start date mm/dd/yyyy	End date mm/dd/yyyy (if known)	Dose (cGy)	Mark if therapy on-going	Start date mm/dd/yyyy	End date mm/dd/yyyy (if known)	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"/>	____/____/____	____/____/____	
Site Unknown	<input type="checkbox"/>	____/____/____	____/____/____		<input type="checkbox"/>	____/____/____	____/____/____	

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

51a. IMRT used: Yes
 No

51b. If yes - Internal Radiation:

Left Breast					Right Breast			
Target Site of Radiation Treatment	Mark if therapy on-going	Start date mm/dd/yyyy	End date mm/dd/yyyy (if known)	Dose (cGy)	Mark if therapy on-going	Start date mm/dd/yyyy	End date mm/dd/yyyy (if known)	Dose (cGy)
Tumor Bed	<input type="checkbox"/>	____/____/____	____/____/____		<input type="checkbox"/>	____/____/____	____/____/____	

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 Side Effects

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

56. If yes, treatment toxicity side effects: Allergic reaction Thrombocytopenia
 Anemia Other
 Clinical cardiotoxicity Specify: _____
 Gastrointestinal
 Myalgia Osteodynia
 Neutropenia Arthralgia
 Neuropathy Leukopenia

Genetic Testing

57. BRCA1 Genetic testing:
(MARK ALL THAT APPLY)

Positive
Specify Variant: _____
 Equivocal
Specify Variant: _____

Negative
 Test not done
 Not documented

57a. If done, how many sites: _____

58. BRCA2 Genetic testing:
(MARK ALL THAT APPLY)

Positive
Specify Variant: _____
 Equivocal
Specify Variant: _____

Negative
 Test not done
 Not documented

58a. If done, how many sites: _____

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: _____	