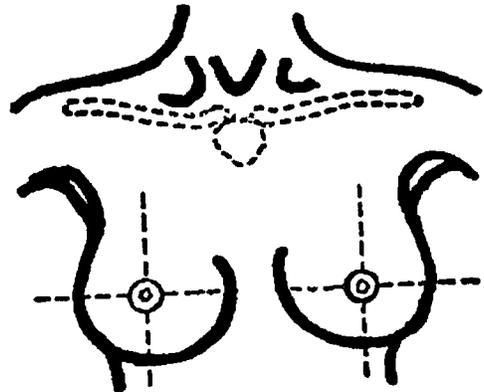


<p>COMMENTS:</p>	<p style="text-align: center;">- Affix label here-</p> <p>Clinical Center/ID: _____</p> <p>First Name _____ M.I. _____</p> <p>Last Name _____</p>
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1. Date of Exam: -- (M/D/Y)
2. Performed By:
3. Contact Type:

<input type="checkbox"/> ₁ Phone	<input type="checkbox"/> ₃ Visit
<input type="checkbox"/> ₂ Mail	<input type="checkbox"/> ₈ Other
4. Visit Type:

<input type="checkbox"/> ₁ Screening	# <input type="text"/>
<input type="checkbox"/> ₂ Semi-Annual	# <input type="text"/>
<input type="checkbox"/> ₃ Annual	# <input type="text"/>
<input type="checkbox"/> ₄ Non-Routine	



5. Summary of clinical breast exam. Record clinical exam notes on back of form.

	Right			Left		
	No	Yes, probably benign	Yes, possibly malignant	No	Yes, probably benign	Yes, possibly malignant
5.1. Nipple discharge	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
5.2. Skin involvement	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
5.3. Axillary mass	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
5.4. Breast mass	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
		↓	↓		↓	↓
For primary mass:						
5.5. Mobile	No <input type="checkbox"/> ₀	Yes <input type="checkbox"/> ₁		No <input type="checkbox"/> ₀	Yes <input type="checkbox"/> ₁	
5.6. Size		<input type="checkbox"/> ₂ < 1 cm		<input type="checkbox"/> ₂ < 1 cm		
		<input type="checkbox"/> ₃ 1-3 cm		<input type="checkbox"/> ₃ 1-3 cm		
		<input type="checkbox"/> ₄ > 3 cm		<input type="checkbox"/> ₄ > 3 cm		
5.7. More than one mass present	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁		<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	

6. Breast self-exam teaching completed/reinforced?

₀ No

₁ Yes

7. Was a referral made for follow-up care?

₀ No

₁ Yes ↘

7.1. Referred by:	<input type="text"/>
7.2. Date of referral:	<input type="text"/>
7.3. Referred to:	
MD/Clinic:	<input type="text"/>
Address:	<input type="text"/>
	<input type="text"/>
Phone:	<input type="text"/>

8. Final Follow-Up Results (Must be documented on Form 89 - Breast Follow-Up)

	Right	Left
Normal	<input type="checkbox"/> ₀	<input type="checkbox"/> ₀
Benign changes	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁
Possibly malignant	<input type="checkbox"/> ₂	<input type="checkbox"/> ₂
Cancer	<input type="checkbox"/> ₃	<input type="checkbox"/> ₃