



**B. Surgeries:**

Did you have a lumpectomy? Yes No

Did you have a mastectomy? Yes No Single Bilateral

If yes, did you have reconstruction? Yes No

Was your reconstruction immediate or delayed? \_\_\_\_\_

What type of reconstruction did you have?

Implant (saline) \_\_\_\_\_ Implant (silicone) \_\_\_\_\_

Free flap \_\_\_\_\_ T.R.A.M. flap \_\_\_\_\_ Latissimus dorsi flap \_\_\_\_\_ DIEP flap \_\_\_\_\_

Did you have a nipple reconstruction? Yes No

Did you have a prophylactic mastectomy? Yes No

Have you had Lymphedema? Yes No

Do you have any additional information regarding your surgeries that you would like us to know?

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**C. Radiation:**

Did you have radiation therapy? Yes No

Did you have brachytherapy or Mammosite? Yes No

**D. Chemotherapy:**

Did you have Chemotherapy? Yes No

If yes, please circle all drugs that apply to you

CAF (or FAC or AC or Adriamycin or doxorubicin)

CMF (or Methotrexate)

CEF (or Ellence or epirubicin)

Taxol

Taxotere

Herceptin (or trastuzumab)

Did you have Chemotherapy before surgery? Yes No

Did you have a bone marrow transplant? Yes No

Did you have a stem cell transplant? Yes No

**E. Drug treatment (Hormonal):**

Are you taking or have you ever taken any of the following?

Tamoxifen (or Nolvadex) Yes No

Raloxifene (or Evista) Yes No

Toremifene (or Fareston) Yes No

Aromatase Inhibitors Yes No

(Arimidex/anastrozole or Femara/letrozole)

Aromatase Inactivators Yes No

(Aromasin/exemestane)

Do you have any additional information about your drug treatment you would like us to know?

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**F. Other Conditions:**

Do you have any other medical conditions that might be helpful for ABCD to know about (for example, other cancers, diabetes, etc.)?

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**G. Complementary treatments:**

Please circle any complementary therapies you've used:

Nutritional          herbal          other \_\_\_\_\_

**Section III:**

If you are fluent in any foreign languages, please list them: \_\_\_\_\_

What is your religion? (optional) \_\_\_\_\_

How important was religion/spirituality in your healing process? (optional):

                very important                  important                  not very important

Please list any disabilities (optional) \_\_\_\_\_

Please list any psychological issues (depression, family conflicts, etc.) (optional) \_\_\_\_\_

Please list any family medical conditions (optional) \_\_\_\_\_

Please list your outside interests and hobbies \_\_\_\_\_

Why would you like to be a volunteer mentor for ABCD? \_\_\_\_\_

\_\_\_\_\_

If you have not had breast cancer, what is your personal experience with this disease?

\_\_\_\_\_

\_\_\_\_\_

What skills do you possess that would help you to be a good mentor?

\_\_\_\_\_

\_\_\_\_\_

**Please complete application and return to:  
ABCD: After Breast Cancer Diagnosis  
6737 W. Washington Street – Suite #3265  
West Allis, WI 53214**