Survivor Member Application

Form ***MUST*** be completed ***BEFORE*** joining
Sisters Network® Inc.

Sisters Network Affiliate Chapter: DALLAS, TEXAS_____

All information provided on this form will be kept CONFIDENTIAL and access to this information will be strictly regulated and monitored. Your data will be entered into the database under a membership number; your name will not be included. The sole purpose of this form is to collect data specifically relating to Sisters Network members. This information will be included in a database which will enable SNI to evaluate and determine which factors, such as family history, early detection practices, treatment variances, types and stages of diagnosis, socio-economic factors, and treatment facilities, play a pivotal role in breast cancer development, diagnosis, treatment, survivorship, quality of life.

Name (PRINT CLEARLY)		Date
Mailing Address	City	Zip
Phone:	Email Address (PRINT CLEARLY)	
Date of Birth (M/D)	Age:	Marital Status (check one): ☐Single ☐ Married ☐Divorce ☐Separated ☐ Widowed
Education: ☐High School ☐Some College ☐College Degree ☐Graduate Degree	I prefer to be contacted by: ☐ Email ☐Phone ☐Text	Add me to the National email list for the latest updates ☐ Yes ☐ No

DIAGNOSIS

Type of Breast Cancer: ☐ Triple Negative ☐ Metastatic ☐ Ductal carcinoma ☐ Lobular carcinoma ☐ Inflammatory ☐ Recurrence

What stage: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Left Breast ☐ Right Breast ☐ Both Date of Diagnosis: _____ Age of Diagnosis: _____

What was your exact diagnosis: _____

Estrogen receptor: ☐ Positive ☐ Negative

How many lymph nodes removed? _____ **How many were positive?** _____

How was the mass/lump detected? ☐ BSE (Breast Self-Examine) ☐ Mammogram ☐ Clinician/Physician (CBE) ☐ Ultra Sound ☐ MRI

TREATMENT

☐ Lumpectomy ☐ Total Mastectomy ☐ Modified radical mastectomy ☐ Bilateral mastectomy ☐ Radical mastectomy ☐ other_____

Date of surgery: _____ Where: _____

Result/Outcome_____

Radiation Therapy: ☐ Yes ☐ No When: _____

Where _____ Result/Outcome_____

Chemotherapy Therapy: ☐ Yes ☐ No When: _____ Type _____

Where _____ Result/Outcome_____

RECURRENCE

Have you had a recurrence? ☐ Yes ☐ No How many? _____ When: _____

Where did the recurrence occur? _____

Family History

Do you have a family history of breast cancer? ☐ Yes ☐ No If yes, who? ☐ Mother ☐ Paternal Grandmother ☐ Maternal Grandmother ☐ Aunt ☐ Sister ☐ Other _____

Do you have children? ☐ Yes ☐ No If yes, age at first pregnancy _____

Have you ever had a previous biopsy? ☐ Yes ☐ No How many? ___ Have you had at least one biopsy with atypical hyperplasia? ☐ Yes ☐

Before diagnosis, were you? Performing monthly breast self-exams ☐ Yes ☐ No Getting annual clinical breast exams ☐ Yes ☐ No
Having annual mammograms ☐ Yes ☐ No