



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 (MM/DD)	Age:	Marital Status (check one): <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorce <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Education: <input type="checkbox"/> High School <input type="checkbox"/> Some College <input type="checkbox"/> College Degree <input type="checkbox"/> Graduate Degree	I prefer to be contacted by: <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Text		Add me to the National email list for the latest updates <input type="checkbox"/> Yes <input type="checkbox"/> No
DIAGNOSIS			
Type of Breast Cancer: <input type="checkbox"/> Triple Negative <input type="checkbox"/> Metastatic <input type="checkbox"/> Ductal carcinoma <input type="checkbox"/> Lobular carcinoma <input type="checkbox"/> Inflammatory <input type="checkbox"/>			
Recurrence			
What stage: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Left Breast <input type="checkbox"/> Right Breast <input type="checkbox"/> Both Date of Diagnosis: _____ Age of Diagnosis: _____			
What was your exact diagnosis: _____			
Estrogen receptor: <input type="checkbox"/> Positive <input type="checkbox"/> Negative			
How many lymph nodes removed? _____ How many were positive? _____			
How was the mass/lump detected? <input type="checkbox"/> BSE (Breast Self-Examine) <input type="checkbox"/> Mammogram <input type="checkbox"/> Clinician/Physician (CBE) <input type="checkbox"/> Ultra Sound <input type="checkbox"/> MRI			
TREATMENT			
<input type="checkbox"/> Lumpectomy <input type="checkbox"/> Total Mastectomy <input type="checkbox"/> Modified radical mastectomy <input type="checkbox"/> Bilateral mastectomy <input type="checkbox"/> Radical mastectomy <input type="checkbox"/> other _____			
Date of surgery: _____ Where: _____			
Result/Outcome _____			
Radiation Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No When: _____			
Where _____ Result/Outcome _____			
Chemotherapy Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No When: _____ Type _____			
Where _____ Result/Outcome _____			
RECURRENCE			
Have you had a recurrence? <input type="checkbox"/> Yes <input type="checkbox"/> No How many? _____ When: _____			
Where did the recurrence occur? _____			
Family History			
Do you have a family history of breast cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who? <input type="checkbox"/> Mother <input type="checkbox"/> Paternal Grandmother <input type="checkbox"/> Maternal Grandmother <input type="checkbox"/> Aunt <input type="checkbox"/> Sister <input type="checkbox"/> Other _____			
Do you have children? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, age at first pregnancy _____			
Have you ever had a previous biopsy? <input type="checkbox"/> Yes <input type="checkbox"/> No How many? _____ Have you had at least one biopsy with atypical hyperplasia? <input type="checkbox"/> Yes <input type="checkbox"/>			
Before diagnosis, were you? Performing monthly breast self-exams <input type="checkbox"/> Yes <input type="checkbox"/> No Getting annual clinical breast exams <input type="checkbox"/> Yes <input type="checkbox"/> No Having annual mammograms <input type="checkbox"/> Yes <input type="checkbox"/> No			