STUDY FORMAT

Name: Hospital Reg.UMRNo:

Age: Sex: FEMALE

Mobile no:

Address: District:

State:

Marital status: Single / married / other

Education:

Occupation: Annual income:

Smoker: yes / no Alcohol: yes / no Tobacco: yes/no

Family history of cancer: yes / no

Other co morbid conditions: Diabetes / HT / Renal / cardiac

Diagnosis: TRIPLE NEGATIVE BREAST CANCER

Stage

Date of Diagnosis:

Height: Weight: BMI: BSA:

PS (at diagnosis):

Treatment:

Chemotherapy: Yes / no

Total number of chemo received:

Cycles of chemotherapy:

Response to Chemotherapy:

RECIST criteria:

Surgery: Yes/no

Date of Surgery:

Type of Surgery:

Radiation therapy Received: Yes/no

Androgen receptor expression (IHC): Positive (>10%)

Or

Negative (<10%)

Date of AR testing:

Tissue for AR testing:

Last follow up date:

Treatment response: