Breast Reconstruction History Questionnaire

Name: ______________________________ **Date of Birth:** ____________________

Please answer the following questions regarding breast cancer.

Do you currently have breast cancer? Yes No

If yes, which breast? Right Breast Left Breast Both Breasts

Do you have a personal history of breast cancer? Yes No

If yes, which breast? Right Breast Left Breast Both Breasts

Did you receive a needle biopsy? Yes No

When were you diagnosed? ______________________________

What type of breast cancer, if known? ______________________________

Have you or do you plan to participate in genetic testing? Yes No

Results of genetic testing: ______________________________

How did you learn of your breast cancer? Self-Breast Exam Mammogram Yearly Woman's Exam

Other: ______________________________

Have you had any of the following breast procedures?

Mastectomy: Yes No Right Left Both When? ____________________

Lumpectomy: Yes No Right Left Both When? ____________________

When was your last mammogram? ______________________________

Do you currently have the following physicians managing your care?

Oncologist: Yes No Name: ____________________

Radiation Oncologist: Yes No Name: ____________________

General Surgeon: Yes No Name: ____________________

Primary Care Physician: Yes No Name: ____________________

Gynecologist: Yes No Name: ____________________

Have you received or plan to receive the following treatments?

Chemotherapy: Yes No Undecided Start Date: __________ End Date: __________

Radiation: Yes No Undecided Start Date: __________ End Date: __________

Hormone Therapy: Yes No Undecided Start Date: __________ End Date: __________

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Please describe your precancerous breast size: ______________ Ideal post-surgical breast size: ________________

Is there a specific type of Breast Reconstruction you are interested in learning more about? Yes No
If yes, which type? ____

Are you interested in receiving contact information for a local breast cancer support group? Yes No

Please answer the following questions regarding your personal and family medical history. Each of these questions contains important factors in determining the type of breast reconstruction best suited for you.

Do you have **<u>personal</u>** history of any of the following? *If yes, please explain.*

Blood Clots or Clotting Disorder: Yes No ____

Heart Surgery: Yes No ____

Abdominal/Pelvic Scars: Yes No ____

Any other Breast Surgery: Yes No ____

MRSA Infection: Yes No ____

Do you have **<u>family</u>** history of any of the following? *If yes, please list who.*

Breast Cancer: Yes No ____

Blood Clots or Clotting Disorder: Yes No ____

Please answer the following regarding pregnancies:

How many children have you given birth to? ___________ How many miscarriages, *if any*? ______________

Were any births a cesarean section? Yes No Did you breastfeed? Yes No

Do you currently smoke or use smokeless tobacco? Yes No Never When did you quit? _________________

Please describe any other medical conditions, *if any*: ____

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____ ___________________________

Patient Signature **Date**

____ ___________________________

Physician Signature **Date**