# KAROL A. GUTOWSKI, MD, FACS

*AESTHETIC SURGERY*
*CERTIFIED BY THE AMERICAN BOARD OF PLASTIC SURGERY*
*MEMBER AMERICAN SOCIETY OF PLASTIC SURGEONS*


## Confidential Health Questionnaire for Breast Implant Revision or Removal

***Please bring your implant information (implant card and surgery report) with you***

Name _____ Today's Date _____

Age _____ Date of Birth _____ Email _____

Address _____ City_____ ZIP _____

Phone Number _____

Emergency Contact _____ Phone Number _____

Primary Care Physician _____ Phone Number _____

**Reason for visit** _____

Bra size before implants _____ Current bra size _____ Desired bra size _____

| | | | |
|---|---|---|---|
| Have you had a mammogram? | No | Yes | Date and result _____ |
| Have you had a physician examine your breasts? | No | Yes | Date and result _____ |
| Do you perform a regular breast self exam? | No | Yes | Details _____ |
| Have you had any problems with your breast? | No | Yes | Details _____ |
| Has anyone in your family had breast problems? | No | Yes | Details _____ |

**IMPLANT HISTORY**

Reason for implants _____
Date implants placed _____ Any revisions? _____

| | | | | | |
|---|---|---|---|---|---|
| Implant maker: | Allergan | Mentor | Sientra | _____ | Don't know |
| Implant type & size: | Saline | Silicone Gel | _____ cc | | Don't know |
| Implant placement: | Above muscle | Below muscle | | | Don't know |
| Implants incision: | Under breast | Around nipple | Armpit | Belly button | |

**MEDICAL INFORMATION**

**Allergies** □ None
□ Medications _____ Reaction _____
□ Environmental _____ Reaction _____
□ Latex Reaction _____

**Medications** (including dietary supplements, nonprescription and herbal products)

**Past Medical History** (list any past or current medical problems)

□ Cold sores or herpes infections

**Past Surgical History** (list any past procedures & operations, including complications)

□ Implant, pacemaker, defibrillator, or implantable medical device

**Social History**

Current Occupation _____
Do you smoke or use tobacco? No Yes
Packs per day _____
Year started _____Year stopped _____
Do you drink alcohol? No Yes
Drinks per week _____
Do you use recreational drugs? No Yes

Marital Status: Married Single Widowed
Number of children _____
Will any dependents rely on you after surgery? _____
Are you planning on having more children? _____
Who will care for you after surgery? _____
Loss of pregnancies or spontaneous abortions _____

**Family Medical History** (please explain if any of these conditions have affected a blood relative)
□ Cancer □ Breast Disease □ Heart disease (heart attacks, heart bypass surgery) □ Abnormal reaction to anesthesia

**Bleeding or Blood Clotting Disorders**
Have you or any blood relative had problems with:
□ Abnormal or excessive bleeding
□ Abnormal or excessive blood clotting, also called Deep Venous Thrombosis (DVT) or Pulmonary Emboli (PE)

**Do you have now, or have you been diagnosed as having** (if yes, please explain)

□ Stroke
□ Thyroid disease
□ Anemia
□ Arthritis
□ Cancer or tumor
□ Diabetes mellitus
□ Heart attack
□ Heart failure
□ Kidney disease
□ Easy bruising
□ Asthma
□ Varicose veins
□ Seizures
□ Palpitations
□ Hepatitis
□ Stomach or duodenal ulcer
□ Stomach or intestinal bleeding
□ Irregular or rapid heart beat
□ High blood pressure
□ Frequent gum or nose bleeds
□ Angina or chest pain
□ Jaundice or liver disease
□ Mood disturbance
□ Heart murmurs
□ Shortness of breath or wheezing
□ Frequent heartburn or reflux
□ Fainting or dizziness
□ Nervous breakdown
□ AIDS or HIV positive
□ Immune disorders

**Height** _____ **Weight** _____ **lbs**

**How did you hear about our practice?**
□ Internet search □ Doctor □ Friend □ Other _____
□ Television □ Magazine □ Web site _____

Who can we thank for this referral? _____

**Completed by** _____ **Signature** _____

*Section below to be completed by physician*

---

**Physical Exam:**

| | | Right | Left |
|---|---|---|---|
| Masses | Notch - Nipple | | |
| Discharge | Upper Pinch | | |
| Skin tone | Nipple - IMF | | |
| Ptosis | Base width | | |
| Skin tone | Areolar width | | |
| | Size | | |
| | IMF | | |

**Impression:**

**Recommendations:**

**Signature** _____ **Date** _____