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

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

If yes, which breast? [ ] Right breast [ ] Left breast [ ] Both

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?

Mastestomy: [ ] 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: _____

Please describe your precancerous breast size: _____ Ideal post-surgical breast size: _____

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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 **personal** 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 **family** history of any of the following? *If yes, please explain.*

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 of use smokeless tobacco? [ ] Yes [ ] No [ ] Never

If yes, when did you quit? _____

Please describe any other medical conditions, if any:

_____

_____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____