New Patient Form – Breast Reconstruction

Name: ______________________________________ Age: ___________

Who referred you to our practice? ____________________________________

Have you visited our website :(www.txdiepflap.com): Yes No
Was our website helpful: Yes No

Please list your physicians below:
Primary care: ____
Ob/Gyn: ____
Surgeon: ____
Medical Oncologist: ____
Radiation Oncologist: ____

Reason for visit: ____

Circle applicable diagnoses: Breast cancer DCIS LCIS BRCA gene mutation
Which side (circle one): Right Left Both

When were you diagnosed: ____
How was it discovered (circle one): Self-exam Physician exam Imaging
How was it diagnosed: Mammogram Ultrasound MRI Biopsy
Date of last mammogram: ________________________________

Are you planning to have a mastectomy (circle one): Yes No Undecided
If yes, which side: Right Left Both Undecided
If already done, enter mastectomy date: _____________________

Will you or have you received chemotherapy? Yes No Unknown
Completion date or expected completion date: _______________

Will you or have you received radiation therapy? Yes No Unknown
Completion date or expected completion date: _______________

Will you or have you had genetic testing? Yes No Unknown
BRCA1 or BRCA2: Positive Negative Unknown

Have you seen or are you planning to see any other plastic surgeons? Yes or No
If yes, which one(s) ____

What is your current bra size? ___________ Desired bra size? ___________

How many pregnancies? ___________ How many deliveries? ___________
Did you breast feed? Yes or No If yes, how many times? ________
Have you ever had a miscarriage? Yes or No If yes, how many? _____

Have you or any family members ever had a blood clot? Yes or No
If yes, please explain: ____

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Medical problems, please circle yes or no:

Diabetes	Yes or No	Arthritis	Yes or No
Heart disease	Yes or No	High cholesterol	Yes or No
Asthma or COPD	Yes or No	Kidney disease	Yes or No
High blood pressure	Yes or No	Bleeding disorder	Yes or No
Thyroid disease	Yes or No	Hepatitis B or C	Yes or No
Anemia	Yes or No	HIV	Yes or No

Other, please list:

____
____
____
____

Previous surgeries, please list:

Procedure: Date: Procedure: Date:

Medications, please list:

Drug: Dose/Frequency: Drug: Dose/Frequency:

Drug Allergies, please list:

Drug: Reaction: Drug: Reaction:

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Family history (1st degree relatives – Parents, siblings, or children):

Diabetes	Yes or No	If yes, who: ______________________
Heart disease	Yes or No	If yes, who: ______________________
High blood pressure	Yes or No	If yes, who: ______________________
Breast cancer	Yes or No	If yes, who: ______________________
Other cancer	Yes or No	If yes, who: ______________________
Anesthesia problems	Yes or No	If yes, who: ______________________
Bleeding disorder	Yes or No	If yes, who: ______________________
Clotting disorder	Yes or No	If yes, who: ______________________

Social history:

Occupation: ____

Where do you live: ____

Who do you live with: ____

How many children: _______________ Ages: ___________________________

Names: ____

Do you smoke: Yes or No

If yes: How many packs per day: _________

Are you willing to quit: Yes or No

Have you tried to quit: Yes or No What methods: ___________

If no, have you ever smoked: Yes or No If yes, quit date: ___________

Do you drink alcohol: Yes or No

If yes, how many drinks per week: _____________________________

Do you or have you ever used recreational drugs: Yes or No

List type: ____

Do you exercise: Yes or No

If yes, how many days per week:_________________________________

Type of exercise:____

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Review of Systems:

System	*Normal*	*Abnormal (Circle all that apply):*
General		Weight loss, weight gain, weakness, fever, fatigue
Skin		Rash, itching, dryness, hair loss, nail changes
Breast		Lump, tenderness, swelling, nipple discharge
Eyes/Ears/Nose/ Throat		Eyes: double vision, tearing, blind spots Ears: pain, discharge, difficulty hearing Nose: bleeding, colds, obstruction, discharge Dental difficulties, gingival bleeding, dentures
Cardiovascular		Chest pain, palpitations, syncope, leg swelling, heart murmur, high blood pressure
Respiratory		Shortness of breath, wheezing, cough, fever or night sweats
Gastrointestinal		Changes in appetite, difficulty swallowing, abdominal pain, heartburn, nausea, vomiting, constipation, diarrhea, changes in bowel habits
Genitourinary		Frequency, urgency, pain with urination, infections, kidney stones, incontinence retention, vaginal discharge,
Musculoskeletal		Joint pain, joint swelling, muscle weakness, muscle cramps, osteoporosis
Neurologic		Seizure, tremor, difficulties with memory or speech, weakness, sensory changes, vertigo, headache
Psychiatric		Anxiety, depression, hallucinations
Immunologic/ Lymphatic		Food allergy, tape allergy, enlargement of lymph nodes or tenderness, cancer
Endocrine		Heat intolerance, cold intolerance, blood sugar abnormalities, increased thirst, frequent urination
Hematologic		Anemia, bleeding disorder, clotting disorder, transfusion reaction

Patient signature: ____________________________________ Date: ____________

Physician signature: ___________________________________ Date: ____________

For staff use only

Height: ____________ Weight: ____________ BMI: ____________

Temp: ____________ BP: ____________ R L HR: ____________ RR: ___________

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