Name: _____ Age: _____
Email address: _____

Who referred you to our practice? _____
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 : Right Left Both
When were you diagnosed: _____
How was it diagnosed: self exam physician exam imaging
Are you planning to have a mastectomy: Yes No Undecided
If yes, which side: Right Left Both Undecided
If already done, enter mastectomy date _____
Will (or have) you received chemotherapy? Yes No Unknown
Completion date or expected completion date _____
Will (or have) you received radiation therapy? Yes No Unknown
Completion date or expected completion date _____
Have you genetic testing done? Yes No
If yes, Result: _____

Date of last mammogram: _____

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? _____ Have you ever had a miscarriage? Yes or No
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:
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	

Have you ever had liposuction: Yes or No (please circle)

If Yes, what areas:_____

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 use any nicotine products : Yes or No

(This includes nicotine gum, lozenges, patches, e-cigarettes, vapors)

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:_____

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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, heart murmur
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: _____

For staff use only

Height: _____ Weight: _____ BMI: _____

Temp: _____ BP: _____ R L HR: _____ RR: _____

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