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: _____

Check 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 ☐
If you have had a previous miscarriage, how many? _____

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

Will you accept blood products if needed? Yes ☐ or No ☐

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Oklahoma City, OK 73120
P 405.246.0391 F 405.246.0392

Medical problems, please check 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 check)

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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