

BREAST RECONSTRUCTION QUESTIONNAIRE

Name _____ Age _____ Height _____ Weight _____

Referring Physician _____ Oncologist _____ Primary Physician _____

Family History of breast cancer? Y N if yes who _____

Occupation _____ Marital Status _____ Pregnancies _____ Live Births _____

Last Mammogram _____ Where? _____ Results _____

Diagnosis(if known) _____ When? _____

Smoke Y N Packs a day _____ Problems with Anesthesia Y N Problems with Bleeding Y N

Previous Surgeries(include dates) _____

Medical Allergies _____ General Allergies _____

Medications(list all include dosage) _____

Have you had or are you scheduled to have Radiation or Chemotherapy Y N(if yes please specify)

Physician Use

BREAST PARAMETERS

LEFT BREAST

RIGHT BREAST

Base Width _____ cm

_____ cm

Breast Height _____ cm

_____ cm

Removed Tissue Weight _____ g

_____ g

Expander Options:

