

Breast Reconstruction Medical History Form

Name: _____ DOB: _____ Date: _____

Do you currently have breast cancer? Yes No

Right Breast Left Breast Both

How did you come to learn you had breast cancer?

Self Breast Exam Mammogram Yearly Woman's Exam

Other: _____

Did you receive a needle biopsy? Yes No

When were you diagnosed? _____

How did you find out about us? / Referred by: _____

Do you have an Oncologist? Yes No Who: _____

Do you have a General Surgeon? Yes No Who: _____

Do you have a Primary Care Physician? Yes No Who: _____

Have you had or have any of the following:

Mastectomy: Yes No Right Left Both When: _____

Lumpectomy: Yes No Right Left Both When: _____

Family History of Breast Cancer: Yes No

Family History of Blood Clots: Yes No

Heart Surgery: Yes No

Scars on your abdomen: Yes No

Hysterectomy: Yes No

Previous Breast Surgery: Yes No Type/Date: _____

Port Catheter: Yes No

Drug Allergies: Yes No if yes, list: _____

Describe any other medical problems:

Have you ever been diagnosed with or are currently being treated for blood clots or blood clotting disorder?

Yes No Details: _____

Have you ever been diagnosed with HIV/AIDS or hepatitis?

Yes No Details: _____

List ALL medications you are currently taking:

Describe any previous surgeries you have had and dates:

Please describe your precancerous and ideal breast size:

Have you had chemotherapy? Yes No When? _____ How many sessions? _____

Have you had radiation? Yes No When? _____ How many sessions? _____

Are you planning on having radiation in the future? Yes No Undecided

Are you planning on receiving hormone therapy in the future? Yes No Undecided

Did you participate in genetic testing? Yes No if yes, conclusion _____

Do you currently smoke?

Yes / How much? _____ No Quit / When? _____

Did you breastfeed? Yes No

How many children have you had? _____ Ages: _____

When was your last mammogram? _____

Are you interested in receiving contact information for a local breast cancer support group? Yes No

Is there a specific type of Breast Reconstruction you are interested in learning more about? Yes No

If yes, which type? _____

Patient Signature

Date

Physician Signature

Date