

LONGWOOD PLASTIC SURGERY, P.C.

Donald J. Morris, M.D./Michael B. Tantillo, M.D./Terri J. Halperin, M.D.

BREAST RECONSTRUCTION QUESTIONNAIRE

(Please fill out to the best of your knowledge)

PATIENT DATA:

DATE: _____

NAME: _____ HEIGHT: _____ WEIGHT: _____ BRA SIZE: _____

GENERAL SURGEON: _____ TELEPHONE NO.: _____

DO YOU HAVE A FAMILY HISTORY OF BREAST CANCER? _____ YES _____ NO

WHO? _____

DO YOU HAVE CHILDREN? _____ YES _____ NO DID YOU NURSE? _____ YES _____ NO

HOW LONG? _____

CLINICAL INFORMATION:

HAVE YOU HAD A MAMMOGRAM? _____ YES _____ NO

RESULTS? _____

HAVE YOU HAD A BIOPSY PERFORMED? _____ YES _____ NO RESULTS? _____

HAVE YOU HAD BREAST SURGERY (i.e., LUMPECTOMY, MASTECTOMY)? _____

DO YOU SMOKE CIGARETTES? _____ YES _____ NO HOW MANY PACKS PER DAY? _____

ARE YOU EXPOSED TO SECOND-HAND SMOKE? _____ HOW OFTEN? _____

HAVE YOU UNDERGONE OR ARE YOU SCHEDULED TO UNDERGO RADIATION? _____ YES _____ NO

IF YES, WHERE/WHEN? _____

HAVE YOU UNDERGONE OR ARE YOU SCHEDULED TO UNDERGO CHEMOTHERAPY? _____ YES _____ NO

IF YES, WHERE/WHEN? _____

PHYSICAL EXAM:

FOR OFFICE USE ONLY

SCARS: R: _____ L: _____ OPPOSITE BREAST: _____

BACK: _____ ABDOMEN: _____

SN>N DISTANCE: R: _____ L: _____ GRAMS/REMOVAL: R: _____ L: _____

PTOSIS: PSEUDO: _____ MILD: _____ MODERATE: _____ MAJOR: _____

SYMMETRY SURGERY: _____

RADIATION INJURY: _____

PATIENT EXPECTATIONS: _____

RECOMMENDATIONS:

1.: _____

2.: _____

3.: _____

4.: _____