**Breast Reconstruction History Questionnaire**

Name: _____ Date of Birth: _____

**Please answer the following questions regarding breast cancer:**

Do you currently have breast cancer? ☐ Yes ☐ No

*If yes, which breast?* ☐ *Right breast* ☐ *Left breast* ☐ *Both*

Do you have a personal history of breast cancer? ☐ Yes ☐ No

*If yes, which breast?* ☐ *Right breast* ☐ *Left breast* ☐ *Both*

Did you receive a needle biopsy? ☐ Yes ☐ No

When were you diagnosed? _____

What type of breast cancer, if known? _____

Have you or do you plan to participate in genetic testing? ☐ Yes ☐ No

Results of genetic testing: _____

**How did you learn of your breast cancer?**

☐ Self-breast exam ☐ Mammogram ☐ Yearly woman's exam ☐ Other: _____

**Have you had any of the following breast procedures?**

Mastestomy: ☐ Yes ☐ No ☐ Right ☐ Left ☐ Both When: _____

Lumpectomy: ☐ Yes ☐ No ☐ Right ☐ Left ☐ Both When: _____

When was your last mammogram? _____

**Do you currently have the following physicians managing your care?**

Oncologist: ☐ Yes ☐ No Name: _____

Radiation Oncologist: ☐ Yes ☐ No Name: _____

General Surgeon: ☐ Yes ☐ No Name: _____

Primary Care Physician: ☐ Yes ☐ No Name: _____

Gynecologist: ☐ Yes ☐ No Name: _____

**Have you received or plan to receive the following treatments?**

Chemotherapy: ☐ Yes ☐ No ☐ Undecided Start Date: _____ End Date: _____

Radiation: ☐ Yes ☐ No ☐ Undecided Start Date: _____ End Date: _____

Hormone Therapy: ☐ Yes ☐ No ☐ Undecided Start Date: _____ End Date: _____

Please describe your precancerous breast size: _____ Ideal post-surgical breast size: _____

**Breast Reconstruction History Questionnaire**

Is there a specific type of Breast Reconstruction you are interested in learning more about?

☐ Yes ☐ No

*If yes, Which Type?* _____

Are you interested in receiving contact information for a local breast cancer support group?

☐ Yes ☐ No

**Please answer the following questions regarding your personal and family medical history. Each of these questions contains important factors in determining the type of breast reconstruction best suited for you.**

Do you have **personal** history of any of the following? *If yes, please explain.*

Blood Clots or Clotting Disorder: ☐ Yes ☐ No _____

Heart Surgery: ☐ Yes ☐ No _____

Abdominal/Pelvic Scars: ☐ Yes ☐ No _____

Any Other Breast Surgery: ☐ Yes ☐ No _____

MRSA Infection: ☐ Yes ☐ No _____

Do you have **family** history of any of the following? *If yes, please explain.*

Breast Cancer: ☐ Yes ☐ No _____

Blood Clots or Clotting Disorder: ☐ Yes ☐ No _____

**Please answer the following regarding pregnancies:**

How many children have you given birth to? _____ How many miscarriages, *if any*? _____

Were any births a cesarean section? ☐ Yes ☐ No Did you breastfeed? ☐ Yes ☐ No

Do you currently smoke of use smokeless tobacco? ☐ Yes ☐ No ☐ Never

*If yes, when did you quit?* _____

Please describe any other medical conditions, if any:

_____

_____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

# Breast Reconstruction History Questionnaire