

KAROL A. GUTOWSKI, MD, FACS

AESTHETIC SURGERY

CERTIFIED BY THE AMERICAN BOARD OF PLASTIC SURGERY

MEMBER AMERICAN SOCIETY OF PLASTIC SURGEONS

Confidential Health Questionnaire for Breast Enhancement

Includes breast augmentation with implants or fat and breast lifts

Name _____ Today's Date _____

Age _____ Date of Birth _____ Email _____

Address _____ City _____ ZIP _____

Phone Number _____

Emergency Contact _____ Phone Number _____

Primary Care Physician _____ Phone Number _____

Reason for visit

Current bra size _____ Desired bra size _____

Have you had a mammogram? No Yes Date and result _____

Have you had a physician examine your breasts? No Yes Date and result _____

Do you perform a regular breast self exam? No Yes Details _____

Have you had any problems with your breast? No Yes Details _____

Has anyone in your family had breast problems? No Yes Details _____

MEDICAL INFORMATION

Allergies None

Medications _____ Reaction _____

Environmental _____ Reaction _____

Latex _____ Reaction _____

Medications (including dietary supplements, nonprescription and herbal products)

Past Medical History (list any past or current medical problems)

Cold sores or herpes infections

Past Surgical History (list any past procedures & operations, including complications)

Implant, pacemaker, defibrillator, or implantable medical device

Social History

Current Occupation _____

Marital Status: Married Single Widowed

Do you smoke or use tobacco? No Yes

Number of children _____

Packs per day _____

Will any dependents rely on you after surgery? _____

Year started _____ Year stopped _____

Are you planning on having more children? _____

Do you drink alcohol? No Yes

Who will care for you after surgery? _____

Drinks per week _____

Loss of pregnancies or spontaneous abortions _____

Do you use recreational drugs? No Yes

Family Medical History (please explain if any of these conditions have affected a blood relative)

Cancer Breast Disease Heart disease (heart attacks, heart bypass surgery) Abnormal reaction to anesthesia

Bleeding or Blood Clotting Disorders

Have you or any blood relative had problems with:

Abnormal or excessive bleeding

Abnormal or excessive blood clotting, also called Deep Venous Thrombosis (DVT) or Pulmonary Emboli (PE)

Do you have now, or have you been diagnosed as having (if yes, please explain)

- | | |
|--|--|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Stomach or duodenal ulcer |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Stomach or intestinal bleeding |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Irregular or rapid heart beat |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Cancer or tumor | <input type="checkbox"/> Frequent gum or nose bleeds |
| <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Angina or chest pain |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Jaundice or liver disease |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Mood disturbance |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Heart murmurs |
| <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Shortness of breath or wheezing |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent heartburn or reflux |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Fainting or dizziness |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Nervous breakdown |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> AIDS or HIV positive |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Immune disorders |

Height _____ **Weight** _____ lbs

How did you hear about our practice?

- | | | | |
|--|-----------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Internet search | <input type="checkbox"/> Doctor | <input type="checkbox"/> Friend | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Television | <input type="checkbox"/> Magazine | <input type="checkbox"/> Web site _____ | |

Who can we thank for this referral? _____

Completed by _____ **Signature** _____

Section below to be completed by physician

Physical Exam:

	Right	Left
Masses	Notch - Nipple	
Discharge	Upper Pinch	
Skin tone	Nipple - IMF	
Ptosis	Base width	
Skin tone	Areolar width	
	Size	
	IMF	

Impression:

Recommendations:

Signature _____

Date _____