Martin | Gutowski

Confidential Health Questionnaire for Breast Implant Revision or Removal

Please bring your implant information (implant card and surgery report) with you

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 _____

Bra size before implants _____ 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 _____

IMPLANT HISTORY

Reason for implants _____

Date implants placed _____ Any revisions? _____

Implant maker:	Allergan	Mentor	Sientra	_____	Don't know
Implant type & size:	Saline	Silicone Gel	_____ cc	Smooth or Textured	Don't know
Implant placement:	Above muscle	Below muscle			Don't know
Implants incision:	Under breast	Around nipple	Armpit	Belly button	

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 _____

Do you smoke or use tobacco? No Yes

Packs per day _____

Year started _____ Year stopped _____

Do you drink alcohol? No Yes

Drinks per week _____

Do you use recreational drugs? No Yes

Marital Status: Married Single Widowed

Number of children _____

Will any dependents rely on you after surgery? _____

Are you planning on having more children? _____

Who will care for you after surgery? _____

Loss of pregnancies or spontaneous abortions _____

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)

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

Height _____ **Weight** _____ **lbs**

How did you hear about our practice?
□ Internet search □ Doctor □ Friend □ Other _____
□ Television □ Magazine □ 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** _____