

## New Patient Form- Breast Reconstruction

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Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Email Address: \_\_\_\_\_

Pharmacy Name and Address: \_\_\_\_\_

Pharmacy Phone: \_\_\_\_\_

How were you referred to our practice? \_\_\_\_\_

Please list your physicians below:

Primary care: \_\_\_\_\_

OB/GYN: \_\_\_\_\_

Surgeon: \_\_\_\_\_

Medical Oncologist: \_\_\_\_\_

Radiation Oncologist: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Circle applicable diagnoses: breast cancer (invasive) DCIS LCIS  
BRCA gene mutation other gene mutation (list):

Which side (circle one): Right Left Both

When were you diagnosed: \_\_\_\_\_

How was it discovered: self exam physician exam imaging

How was it diagnosed: mammogram ultrasound MRI biopsy

Date of last mammogram: \_\_\_\_\_

Are you planning to have a mastectomy (circle one): Yes No Undecided

If yes, which side: Right Left Both Undecided

If already done, enter mastectomy date: \_\_\_\_\_

Are you planning to have a lumpectomy (circle one): Yes No Undecided

If yes, which side: Right Left Both Undecided

If already done, enter lumpectomy date: \_\_\_\_\_

Will you or have you received chemotherapy? Yes No Unknown

Completion date or expected completion date: \_\_\_\_\_

Will you or have you received radiation therapy? Yes No Unknown

Completion date or expected completion date: \_\_\_\_\_

Have you seen or are you planning to see any other plastic surgeons?

Yes or No

If yes, which one(s) \_\_\_\_\_

What is your current bra size (band and cup)? \_\_\_\_\_ Desired bra size? \_\_\_\_\_

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How many pregnancies? \_\_\_\_\_ How many deliveries? \_\_\_\_\_  
 Did you breast feed? Yes No If yes, how many times? \_\_\_\_\_  
 Have you ever had a miscarriage? Yes No If yes, how many? \_\_\_\_\_

Have you or any family members ever had a blood clot? Yes No  
 If yes, please explain: \_\_\_\_\_

**Medical problems, please circle yes or no:**

Diabetes	Yes	No	Arthritis	Yes	No
Heart disease	Yes	No	High cholesterol	Yes	No
Asthma or COPD	Yes	No	Kidney disease	Yes	No
High blood pressure	Yes	No	Bleeding disorder	Yes	No
Thyroid disease	Yes	No	Hepatitis B or C	Yes	No
Anemia	Yes	No	Depression	Yes	No
Other cancer	Yes	No	HIV	Yes	No
Other, please list: _____					
_____					
_____					

**Previous surgeries, please list:**

Procedure:	Date:	Procedure:	Date:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Medications, please list:**

Drug:	Dose/Frequency:	Drug:	Dose/Frequency:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Drug allergies, please list:**

Drug:	Reaction:	Drug:	Reaction:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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**Family history** (1<sup>st</sup> degree relatives – parents, siblings, or children):

Diabetes	Yes	No	If yes, who: _____
Heart disease	Yes	No	If yes, who: _____
High blood pressure	Yes	No	If yes, who: _____
Breast cancer	Yes	No	If yes, who: _____
Other cancer	Yes	No	If yes, who & type: _____
Anesthesia problems	Yes	No	If yes, who: _____
Bleeding disorder	Yes	No	If yes, who: _____
Clotting disorder	Yes	No	If yes, who: _____

Children, if applicable. Please list age(s) and sex(es):

\_\_\_\_\_

**Social history:**

Job title/employer: \_\_\_\_\_

Who do you live with? \_\_\_\_\_

Marital status (circle one): Single   Married   Divorced   Widowed

Do you smoke: Yes   No

If yes: How many packs per day: \_\_\_\_\_

Are you willing to quit: Yes   No

Have you tried to quit: Yes   No

What methods: \_\_\_\_\_

If no, have you ever smoked: Yes   No

If yes, quit date: \_\_\_\_\_

Do you drink alcohol: Yes   No

If yes, how many drinks per week: \_\_\_\_\_

Do you or have you ever used recreational drugs: Yes   No

List type: \_\_\_\_\_

Do you exercise: Yes   No

If yes, how many days per week: \_\_\_\_\_

Type of exercise: \_\_\_\_\_

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**Review of Systems: Please circle symptoms you are experiencing today. If normal, check Normal column.**

<b>System</b>	<b>Normal</b>	<b>Abnormal (circle all that apply):</b>
<b>General</b>		Weight loss, weight gain, weakness, fever, fatigue
<b>Skin</b>		Rash, itching, dryness, hair loss, nail changes
<b>Breast</b>		Lump, tenderness, swelling, nipple discharge
<b>Eyes/Ears/Nose/Throat</b>		Eyes: double vision, tearing, blind spots Ears: pain, discharge, difficulty hearing Nose: bleeding, colds, obstruction, discharge Dental difficulties, gingival bleeding, dentures
<b>Cardiovascular</b>		Chest pain, palpitations, syncope, leg swelling, heart murmur, high blood pressure
<b>Respiratory</b>		Shortness of breath, wheezing, cough, night sweats
<b>Gastrointestinal</b>		Changes in appetite, difficulty swallowing, abdominal pain, heartburn, nausea, vomiting, constipation, diarrhea, changes in bowel habits
<b>Genitourinary</b>		Frequency, urgency, pain with urination, infections, kidney stones, incontinence, retention, vaginal discharge
<b>Musculoskeletal</b>		Joint pain, joint swelling, muscle weakness, muscle cramps, osteoporosis
<b>Neurologic</b>		Seizure, tremor, difficulties with memory or speech, weakness, sensory changes, vertigo, headaches
<b>Psychiatric</b>		Anxiety, depression, hallucinations
<b>Immunologic/Lymphatic</b>		Food allergy, tape allergy, enlargement of lymph nodes or tenderness, cancer
<b>Endocrine</b>		Heat intolerance, cold intolerance, blood sugar abnormalities, increased thirst, frequent urination
<b>Hematologic</b>		Anemia, bleeding disorder, clotting disorder, transfusion reaction

Patient signature: \_\_\_\_\_

Date: \_\_\_\_\_