Baylor College of Medicine,
Division of Plastic Surgery
Breast Reconstruction Patient History Form

THE CENTER for BREAST RESTORATION

Date: _____ **Patient Name:** _____ **Age:** _____

Birthdate: _____ **Weight** _____ **Height** _____ **Breast Size** _____

Primary Care Doctor:_____ **Referring Doctor:** _____
Oncologist: _____ **General Surgeon:** _____

History of Present Illness: When did the condition first occur? _____
How was it diagnosed?: Self ☐ Mammogram ☐ Physician ☐
What side is the tumor on? RIGHT ☐ LEFT ☐ BOTH ☐
What type of tumor (if known)? DCIS ☐ Invasive Ductal ☐ Lobular ☐
Describe any treatment you have had so far (including reconstruction if any):

_____
_____
_____

Radiation Therapy:
Duration: from _____to_____
Quantity_____
Chemotherapy:
Duration: from _____to_____
Medication _____

Past Medical History: Have you ever had the following?

	No	Yes		No	Yes		No	Yes
Heart disease	☐	☐	Blood Clots	☐	☐	Stomach Ulcer	☐	☐
Arthritis	☐	☐	Glaucoma	☐	☐	Kidney disease	☐	☐
Rheumatic Fever	☐	☐	Asthma	☐	☐	Thyroid Disease	☐	☐
Anemia	☐	☐	AIDS or HIV	☐	☐	Bleeding tendency	☐	☐
Tuberculosis	☐	☐	Stroke	☐	☐	Mitral Valve Prolapse	☐	☐
Diabetes	☐	☐	Hepatitis	☐	☐	High Blood Pressure	☐	☐

List any major illnesses and dates:

Date	Illness
_____	_____
_____	_____
_____	_____

Past Surgical History
List all your previous surgeries and dates

Date	Procedure
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Drug allergies: _____

Current Medications: (please include aspirin, ibuprofen, birth control pills etc. and dosage)

Medication	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History:

Type of Cancer: List any blood relative with cancer	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

Bleeding Disorders: Have you or any of your relatives had problems with blood clots or bleeding?

_____

Social History:

Smoking (type & amount per day) _____ If former smoker, date quit: _____
Alcohol (type and amount per week) _____
Occupation: _____ Marital Status: _____
Spouse Occupation: _____ Number of Children: _____

Physical Activity Level: How often do you exercise? _____
What type of activities do you enjoy? _____
Does your work require any physical activity? No ☐ Yes☐ Do you have back pain? No ☐ Yes☐

Review of Systems: Do you have now or have you had within the past year:

	No	Yes		No	Yes		No	Yes
Weight Change	☐	☐	Swollen feet/ankles	☐	☐	Seizures	☐	☐
Dry eyes	☐	☐	Skin rash	☐	☐	Joint or muscle pain	☐	☐
Chronic cough	☐	☐	Chronic diarrhea	☐	☐	Swollen lymph nodes	☐	☐
Chest pain	☐	☐	Jaundice	☐	☐	Easy bleeding	☐	☐
Rapid heart beat	☐	☐	Depression	☐	☐	Easy bruising	☐	☐
Abdominal Pain	☐	☐	Heartburn Reflux	☐	☐	Urinary Symptoms	☐	☐

Age period began _____ Number or pregnancies _____
Date of last mammogram _____ Did you breast feed? No ☐ Yes☐
Do you do regular breast self-examinations? No ☐ Yes☐ Breast lump or discharge No ☐ Yes☐

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

x _____ _____ x _____
Signature of patient or parent if minor Date Signature of Physician