



Basic Screening Medical History

Immediate vs Delayed	Date	DellaCroce, Sullivan, Trahan MD
	Procedure	
	Mastectomy	
	Prophylactic	

PERSONAL INFORMATION

Name: _____ Phone(h): _____
 Address: _____ Work: _____
 City: _____ State: _____ Cell: _____
 Zip: _____ DOB: _____ Fax: _____
 Email: _____ SSN: _____
 Ht: _____ Wt: _____ Bra Size: _____ Size Desired: _____ Referred by: _____
 Marital State: _____ Children: _____ Occupation: _____

BREAST CANCER

Do you currently have cancer? _____ (If yes, send biopsy and mammogram reports)
 What type of Cancer: _____ When were you diagnosed? _____
 Stage if known: _____ Where lymph nodes removed? _____
 Treating Physician: _____ Estrogen/Progesterone positive? _____ HER2/neu? _____
 Did you have a mastectomy / or need one? _____ Side: _____
 Do you need a prophylactic mastectomy? _____ Side: _____ (If prophylactic and not BRCA, get M.D. letter)
 Have you had a previous reconstruction? _____ Type: _____ Saline Silicone Size: _____
 Problems with previous reconstruction: _____

FORM OF TREATMENT

Chemo: _____ Date completed: _____ Complications: _____
 Radiation: _____

TESTS

Have you tested for the BRCA gene / result: _____ (Request a copy of results and genetic report)
 Has any relative tested for the BRCA gene / result: _____
 List family members with hx of Breast CA: _____ Ovarian CA: _____

MEDICAL HISTORY

List all medications, vitamins, otc herbal supps currently taking: _____

 List any allergies: _____



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Have you been dx or treated for: (Explain below)

Heart Disease: _____ HTN: _____ Diabetes: _____ Kidney Disease: _____ DVT: _____
Lung Disease: _____ Cancer (other than breast): _____ Asthma: _____
Hepatitis: _____ Bleeding Disorder: _____

List additional medical hx: _____

PREVIOUS SURGERIES

Surgery / date: _____

PROBLEMS WITH GENERAL ANESTHESIA IN THE PAST:

Do you smoke? _____ / ppd / _____ Years. Are you currently using any nicotine products, ie meds, patch, gum _____

Do you drink alcohol? _____ Type / Amount? _____

ADDITIONAL INFO AND INSTRUCTIONS GIVEN TO THE PATIENT

RELIGIOUS / CULTURAL RESTRICTIONS TO BLOOD PRODUCTS _____

HOBBIES _____

EMPLOYER INFORMATION

Employed FT _____ Employed PT _____ Not Employed _____ Self-Employed _____

Employee: _____

Employee Address: _____

Employee Phone Number: _____