



Basic Screening Medical History

Immediate Delayed Date _____ Doctor: DellaCroce | Sullivan | Trahan
 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: _____ High Blood Pressure: _____ Diabetes: _____
 Kidney Disease: _____ Deep Vein Thrombosis / Blood Clots: _____
 Lung Disease: _____ Cancer (other than breast): _____ Asthma: _____
 Hepatitis: _____ Bleeding Disorder: _____
 Have you had any of these tests in the past year? EKG Stress Test Chest Xray

List additional medical hx: _____

PREVIOUS SURGERIES

Surgery / date: _____

PROBLEMS WITH GENERAL ANESTHESIA IN THE PAST:

Do you smoke? Have you ever smoked? Yes No How Long? _____
 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: _____