

CENTER FOR NATURAL BREAST RECONSTRUCTION
PATIENT HISTORY FORM

Name: _____ Date: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Age: _____ Birthdate: _____ Marital Status: _____ Pre-Mast
Bra Size: _____

Height: _____ Weight: _____ Children # _____ Ages: _____ Vag: _____ C-section: _____

Smoke: _____ How Much: _____ Alcohol: _____ How Much: _____

Occupation: _____

Allergies: _____

Medications: (Including OTC, Vitamins, & Herbal Supplements) _____

Medical HX: Heart Disease _____ HTN _____ Diabetes _____ Kidney _____ Asthma _____

DVT _____ Other _____

Past Surgeries: _____

Abdominal Surgery?: _____

Chemotherapy?: _____

Radiation?: _____

Anesthesia Problems?: _____

Family HX of Breast/Ovarian Cancer: _____

Complications from Chemo/Radiation: _____

Breast Cancer HX: _____ Date of Mast: _____ L-R-Bilateral

Description: _____

Breast Surgeon: _____ Prev. Reconstruction: _____

Complications: _____

Insurance Company: _____ ID # _____