BREAST RECONSTRUCTION WORKSHEET

PATIENT DATA

Name:____ Date:______________________________
Age:_______ Height:________ Current Weight:________ Goal Weight:_________
Weight Fluctuations:_________________________
Marital Status (Married/Single/Etc)?_____________________________

Number of Pregnancies:__________ Number of Births:__________ Number of Times Breastfed:___________
Are You Planning To Have Future Pregnancies? Yes No
Are You Planning To Breastfeed? Yes No

Are You Post-Menopausal? Yes No

BREAST SYMPTOMS – check all that apply

☐ Breast pain ☐ Difficulty with clothing ☐ Painful incisions/scars
☐ Neck pain ☐ Difficulty with posture ☐ Arm swelling, lymphedema
☐ Back pain ☐ Difficulty with exercising ☐ Decreased range of motion of your arm(s)
☐ Skin changes due to radiation (redness, swelling) ☐ Skin irritation/ulcerations/rashes
☐ Nipple bleeding ☐ Nipple discharge ☐ Painful incisions/scars
☐ Nerve symptoms (for example: tingling, numbness, burning in the breast, chest, arms, hands)

☐ Other: ____

Please describe your symptoms:
____
____
____
____

EXPECTATIONS:

Breast Size/Bra Prior to any Breast Surgery:_____________________________
Current Size/Bra:_____________________________
Desired Size/Bra:_____________________________

What are your goals for your breast reconstruction?____
____
____

Is there anything you wish to avoid with your breast reconstruction?______________________________
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PLEASE LIST ANYTHING ELSE YOU WOULD LIKE US TO KNOW:

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