Plastic and Reconstructive Surgery at the Helen F. Graham Cancer Center

4701 Ogletown-Stanton Rd. West Entrance, Suite 1340, Newark DE 19713 (302) 623-4343

NAME: _____BIRTHDATE: _____APPOINTMENT DATE: _____

REASON FOR VISIT: _____

Primary Care Doctor: _____Breast Surgeon: _____Oncologist: _____

MEDICATION:

Current Birth Control: _____ Approximate Dates Taken: _____
Hormone Replacement Therapy(*current*): _____ Approximate Dates Taken: _____
Hormone Replacement Therapy(*past*): _____ Approximate Dates Taken: _____
Tamoxifen or other Anti-Estrogen medication (*dates taken)* _____
Do you take an aspirin daily? __yes __ no
Are you taking other blood thinning medications? __ yes __ no (*if yes, please tell us which one(s)?*) _____
_____

ALLERGIES:

Are you allergic to any medication? *(please circle and list all medications and the reaction)*:
_____
_____

Latex *(please circle)*: Yes / No
Adhesive (*please circle*): Yes / No
Other Allergies: _____

*Have you undergone Genetic consultation/testing? If yes, when and what was the result? _____
What is your current bra size? _____ What size would you like to be (approx..) after surgery? _____

MEDICAL HISTORY: Please check all that apply to you.

__ Anti-phospholipid Antibody Syndrome
__ Anxiety
__ Atherosclerosis or arteriosclerosis
__ Atrial Fibrillation (irregular heart beat)
__ Blood Disease (Antithrombin III, Factor VIII)
__ Blood Transfusions
__ Cancer – Breast ___Left _____Right
__ Cancer _____
__ Chronic Bronchitis/cough
__ Chronic Renal (Kidney) Insufficiency /Failure
__ CHF (Heart Failure)
__ COPD
__ Coronary Artery Disease (Heart Disease)
__ CVA/TIA (Stroke)
__ Deep Vein Thrombosis (DVT)
__ Depression
__ Diabetes Type 1
__ Diabetes Type 2
__ Dialysis ___Hemodialysis ___Peritoneal
__ Easy bruising, excessive bleeding
__ Factor V Leiden
__ Family History of Blood Clots
__ Fibrinolysis
__ Genetic Mutation _____
__ GI bleed (internal bleed)
__ Heart Attack
__ Heart Failure
__ Heart murmur or arrythmia
__ Hepatitis: __C __B __ other
__ HIV Infection
__ Hypertension (high blood pressure)
__ Hyperhomocysteinemia
__ Hypotension (low blood pressure)
__ Hypothyroidism (Low Thyroid)
__ Hyperthyroidism (High Thyroid)
__ Infertility
__ Inflammatory Bowel Disease
__ Keloids (hypertrophic scar condition)
__ Lymphedema
__ Nephrotic Syndrome (kidney dysfunction)
__ Oral Contraceptive Medications
__ Peripheral Arterial Disease
__ Peripheral Vascular Disease
__ Platelet disorder (Bleeding disorder)
__ Polycythemia Vera or Essential Thrombocytosis
__ Protein C or S Deficiencies
__ Prothrombin Gene Mutation
__ Pulmonary Embolism (PE)
__ Recent Trauma
__ Scleroderma
__ Sickle Cell Anemia
__ Sickle Cell Trait
__ Thrombophlebitis (blood clots)
__ Transplant Recipient- type/date_____

STAFF USE ONLY

Height: _____ BP_____
Weight: _____ HR _____
BMI: _____ T _____
% BF: _____

SURGICAL HISTORY: Please check all that apply to you and add DATE of procedure:

Heart and Lung:
__ CABG (Open Heart)
__ Cardiac (Heart) Stents
__ Cardiac Catheterization (Percutaneous Angioplasty)
__ Cardiac Pacemaker or Defibrillator
__ Valve Replacement
__ Pulmonary (Lung) Surgery

Abdominal:
__ Abdominoplasty (Tummy Tuck)
__ Appendectomy
__ Cholecystectomy (removal of gall bladder)
__ Gastric Band/Sleeve/Bypass
__ Hernia Repair: Location_____
__ C-Section _____
__ Hysterectomy (Removal of uterus)
__ Hysterectomy w/USO (Removal of 1 ovary)
__ Hysterectomy w/BSO (Removal of both ovaries)
__ Nephrectomy (Removal of kidney)
__ Tubal Ligation
__ Urinary Incontinence Surgery
__ Uterine Ablation
__ Other Abdominal Surgery

Vascular:
__ Amputation
__ Aortic Aneurysm Repair
__ Carotid Artery Stenting/Angioplasty
__ Fistula Surgery
__ Inferior Vena Cava Filter Placement/Retrieval
__ Mesenteric/Renal Artery Bypass/Endarterectomy
__ Stenting to repair aneurysms
__ Thoracic Outlet Decompression
__ Vertebral Artery Reconstructions

Breast/Axillae:
__ Axillary Node Dissection – Left
__ Axillary Node Dissection – Right
__ Core (Biopsy Left Breast)
__ Core (Biopsy Right Breast)
__ Augmentation __Left __Right
___Saline ___Silicone
__ Excisional Biopsy – Left: _____
__ Excisional Biopsy – Right: _____
__ Reduction Mammoplasty (Breast Reduction)
__ Implant Reconstructive – (Left breast)
__ Implant Reconstructive – (Right breast)
__ Partial Mastectomy –Left (Lumpectomy)
__ Partial Mastectomy –Right (Lumpectomy)
__ Total Mastectomy – Left
__ Total Mastectomy – Right
__ Sentinel Node Biopsy Left
__ Sentinel Node Biopsy Right
__ TRAM/Latissimus Dorsi Flap
__ DIEP/SGAP
__ Port Placement, ___Port Removal
__ SAVI catheter placement

__ Other _____
__ Other_____

Do you have a history of problems with anesthesia:
___ yes ___no (*yes, please describe*) _____

Have you ever had any significant bleeding *after* surgery? _____

OBSTETRIC HISTORY:
Number of Pregnancies: _____ Number of children: _____ Age at first delivery: _____ Breast Fed: __yes __no
Number of Miscarriages: _____

FAMILY MEDICAL HISTORY: (does not include the patient): Please check all that apply.
__ Blood Clots/bleeding issues
__ Stroke (< age 50)
__ High blood pressure
__ Heart attack (< age 50)
__ Diabetes

SOCIAL HISTORY:
Marital Status: _____ Employment status: _____ Occupation (include even if retired): _____
With whom do you currently live? _____
Frequency of Caffeine Use: _____
Frequency of Alcohol Use: (circle one) Daily / Weekly / Socially / Never
Frequency of Marijuana Use: (circle one) Daily / Weekly / Socially / Never
Frequency of Exercise (30 minutes of cardiovascular exercise): (circle one) Daily / 2-3 Times per Week / Weekly / Never

SMOKING:
__ Never smoked
__ Current smoker (Years: ____ Packs Per Day: ____ Everyday __ Occasional __)
__ Former smoker, Year Quit _____

PAIN:
Are you having pain today? ___ Yes ___ No Where: _____
On a scale of 0 to 10 *(0 = no pain, 10 = worst pain of your life)*, What number would you give your pain? ____