

**The Center for Plastic Surgery at Sentara**

**Breast Intake Form**

At what age did you first start menstruating?

Date of last menstrual period?

|  |  |  |  |
| --- | --- | --- | --- |
|  | YES | NO |  |
| Have you had a hysterectomy?  |   |   |  |
| If so, what date? |   |   |  |
| Are you currently Menopausal? |   |   |  |
| If so, what date did Menopause begin? |   |   |  |
| Family history of breast cancer? |   |   |  |
| If yes, who? |   |   |  |
| Have you had any breast biopsies? |   |   |  |
| If yes, indicate findings: |   |   |  |
| Personal history of breast cancer: |   |   | Date of DX? |
| a. Did you do chemotherapy? |   |   | Date of last treatment? |
| b. Did you do radiation? |   |   | Date of last treatment? |
| c. Are you in remission? |   |   | Date remission began? |
| d. Are you BRCA positive? |   |   |   |
| Personal history of other cancers? |   |   |  |
| If yes, what type and what date of DX? |   |   |  |
| Previous history of breast surgery: |   |   |  |
| If yes, please list date and procedure? |   |   |  |

Please make below as indicated:



|  |  |  |
| --- | --- | --- |
|  | YES | NO |
| Do you have breast implants? |   |   |
| If yes, what type: Saline Silicone Not Sure |   |   |
| Have they been replaced? |   |   |
| Do you have breast tissue expanders? |   |   |
| Prior breast imaging: |   |   |
| Mammogram? |   |   |
| Breast Ultrasound? |   |   |
| Breast MRI? |   |   |
| Are you currently taking hormones? |   |   |
| If yes, what type:  |   |   |
| Last dose? |   |   |
| Are you currently taking birth control? |   |   |
| If yes, what type: Oral Implant IUD |   |   |
| Current Occupation: |   |   |
| Are you Right or Left Handed? |   |   |
| Do you currently Smoke? |   |   |
| Are there rashes under breast (s)? |  |  |
| If yes, how many packs per day? |   |   |
| Do you have back pain |  |  |
| Do you have allergies? |   |   |
| If yes, please list: |   |   |

Do you have a history of any of the following? If so, please circle all that apply:

Asthma COPD Diabetes Hypertension

Hemophilia Heart Disease Heart Failure

Bra size? \_\_\_\_\_\_\_\_\_\_\_

Shoulder Strap Grooving \_\_\_\_\_\_\_\_\_\_

Do you have any creams or powders prescribed by PCP? \_\_\_\_\_\_\_\_\_\_

If so, what are they? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_