Carolinas Healthcare System Breast Reconstruction Patient Form

Please fill out the information below. If you have any questions, please let us know and we will be happy to help you.

My Health Problem (put a ✓ next to your answer)

Ductal Carcinoma in Situ (DCIS)  ______ Right Breast  ______ Left Breast
Breast Cancer  ______ Right Breast  ______ Left Breast

Have you tested positive for these genes?  ______ BRCA 1  ______ BRCA 2
Any other genes you tested positive for that we should know about? _____________________________

Have you been treated with chemotherapy?  ______ Yes  ______ No  ______ Don’t know
Have you been treated with Radiation Therapy?  ______ Yes  ______ No  ______ Don’t know

What breast procedures you have had in the past?

<table>
<thead>
<tr>
<th>Procedure</th>
<th>When did you have this done (date)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

What abdomen (stomach) procedures you have had in the past?

<table>
<thead>
<tr>
<th>Procedure</th>
<th>When did you have this done (date)?</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

What is the reason you want to get breast reconstruction (rebuild the shape look of your breasts)?

_____ Thinking about mastectomy (surgery to remove your breasts)
_____ Had mastectomy in the past
_____ Thinking about lumpectomy (surgery to take out a mass of tissue from your breast)
_____ Had lumpectomy in the past
_____ Fix a deformity (flaw) in your breast that you have had for a long time
_____ Problem with breast implants
Have you talked to another Plastic Surgeon about breast reconstruction?  ____ Yes  ____ No

What do you want to use for your breast reconstruction?
____ My own tissue  ____ Implant  ____ I’m not sure

Do you want your reconstructed breast(s) to be:
____ Same size as they are now  ____ Larger than they are now  ____ Smaller than they are now
____ I’m not sure

Would you be okay with doing surgery on your other breast to make them the same size? If the doctor thinks this is best?
____ Yes  ____ No  ____ Don’t know

Do you smoke?  ____ Yes  How many cigarettes do you smoke each day? __________

How long have you smoked? ____________________________

____ No  Did you ever smoke? __________

How long did you smoke? ____________________________

Please sign your name below:

Signature ____________________________  Date ___________________  Time ____________

Approved by Atrium Health Corporate Health Literacy, March 2018

Carolina HealthCare System complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-821-1535.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-821-1535.

Rev 04/18
Page 2 of 2  Patient Label
# Physical Reconstruction Breast Exam

![Breast Diagram]

**Patient Label**

**Rev: 03/18**

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### Physical Reconstruction Breast Exam

<table>
<thead>
<tr>
<th><strong>Breast Parameters</strong></th>
<th><strong>Right Breast</strong></th>
<th><strong>Left Breast</strong></th>
<th><strong>Plan</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Width</td>
<td>___________</td>
<td>___________</td>
<td>Immediate or Delayed</td>
</tr>
<tr>
<td>Suprasternal Notch</td>
<td>___________</td>
<td>___________</td>
<td>TE</td>
</tr>
<tr>
<td>Nipple to Inframammary Fold</td>
<td>___________</td>
<td>___________</td>
<td>Implant</td>
</tr>
<tr>
<td>Shoulder Level:</td>
<td>___________</td>
<td>___________</td>
<td>DIEP</td>
</tr>
<tr>
<td>IMF Level:</td>
<td>___________</td>
<td>___________</td>
<td>CTA</td>
</tr>
<tr>
<td>Asymmetry:</td>
<td>___________</td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>Scars:</td>
<td>___________</td>
<td></td>
<td>Follow Up: ___________</td>
</tr>
<tr>
<td>Ptosis:</td>
<td>I II III</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen Scars:</td>
<td>___________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Abdominal Volume Estimate:** Smaller Similar Larger (vs Breast Volume)

**Hernia:** Yes No

**Rectus Diastasis:** Yes No

**Signature** _________________________________  **Date** ____________________  **Time** ____________________