REGENESIS
PLASTIC SURGERY AND SKIN CARE CENTER

2643 Patterson, Suite 506 * St. Mary's Physician's Tower * Grand Junction, Colorado 81506 * 970-242-8177 * fax: 970-255-3558

Date ___________________

Confidential Health Questionnaire for Breast Reduction

Patient Name ___________________________________ Date of birth ____________________________Age __________

Primary Care Physician ___________________________ Referring Physician _____________________________________

Reason for visit ____

Current bra size ________ Desired bra size ________

Have you had a mammogram? No ☐ Yes ☐ Date:_________ ☐ Results:____________________
Have you had a physician examine your breasts? ☐ No ☐ Yes ☐ Date:_________ ☐ Results:____________________
Do you perform a regular breast self exam? ☐ No ☐ Yes ☐ Abnormalitis:______________________________
Have you had any problems with your breast? ☐ No ☐ Yes ☐ Date:_________ ☐ Details:____________________
Has anyone in your family had breast problems? ☐ No ☐ Yes ☐ Explain:__________________________________

Which of the following problems do you have that may be related to you breasts?
☐ Back pain ☐ Neck pain ☐ Shoulder pain ☐ Breast pain ☐ Rashes under breasts
☐ Poor posture ☐ Headaches ☐ Hand numbness ☐ Grooves in shoulders from bra

What have you tried to make these problems better?
☐ Medications ☐ Physical therapy ☐ Weight loss ☐ Special bras ☐ Chiropractic treatment

In what way does your breast size interfere with normal activities? ____

MEDICAL INFORMATION
Allergies ☐ None ☐ Penicillin ☐ Latex ☐ Sulfa ☐ Iodine ☐ Codeine
DRUG: REACTION:
☐ ________________________ ____
☐ ________________________ ____
☐ ________________________ ____

Medications (including dietary supplements, nonprescription and herbal products)
NAME: DOSAGE: FREQUENCY:
1.______________________ _______ _______________________________
2.______________________ _______ _______________________________
3.______________________ _______ _______________________________
4.______________________ _______ _______________________________
5.______________________ _______ _______________________________

Surgeries: (Please list all previous surgeries including approximate date)
1.__________________________________ 4.__________________________________
2.__________________________________ 5.__________________________________
3.__________________________________ 6.__________________________________

Has the patient ever had a serious reaction to anesthesia? ☐ No ☐ Yes:____
Social History

Current Occupation: ____________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed ☐ Other

Do you smoke or chew tobacco? ☐ Never ☐ Some Days ☐ Daily ☐ Former Smoker
How many packs per day?__________ When did you quit?________

Do you drink alcohol? ☐ No ☐ Rarely ☐ Weekly ☐ Daily

Do you use recreational drugs? ☐ No ☐ Yes:____________________

Review of Systems (Current symptoms)

GENERAL:
- ☐ Anorexia
- ☐ Appetite Loss
- ☐ Chills
- ☐ Excessive Crying
- ☐ Fatigue
- ☐ Fever
- ☐ Significant Weight Change

SKIN:
- ☐ Bruising
- ☐ Change in Wart/Mole
- ☐ Excessive Sweating
- ☐ New Lesion
- ☐ Rash

HEENT:
- ☐ Dentures
- ☐ Difficulty swallowing
- ☐ Nose bleeds
- ☐ Headaches
- ☐ Recurrent sinusitis
- ☐ Hearing loss
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Dizziness
- ☐ Wears glasses
- ☐ Wears contacts
- ☐ Glaucoma
- ☐ Facial numbness/tingling
- ☐ Trouble opening mouth

NECK:
- ☐ Mass
- ☐ Pain
- ☐ Swollen glands
- ☐ Stiffness

RESPIRATORY:
- ☐ Wheezing
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Shortness of Breath
- ☐ Constant cough

CARDIOVASCULAR:
- ☐ Low blood pressure
- ☐ Chest pains
- ☐ Irregular heart beat

BREAST:
- ☐ Mass
- ☐ Pain
- ☐ Swelling
- ☐ Discharge
- ☐ Gynecomastia
- ☐ Skin Changes

GASTROINTESTINAL:
- ☐ Urinary infections
- ☐ Heartburn
- ☐ Colitis
- ☐ Chronic diarrhea
- ☐ Jaundice
- ☐ Pancreatitis
- ☐ Hernia

MUSCULOSKELETAL:
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Limited joint motion
- ☐ Muscle weakness

BLOOD:
- ☐ Anemia
- ☐ Sickle cell disease/trait
- ☐ Easily bruised

NEUROLOGICAL:
- ☐ Numbness or Tingling
- ☐ Head injury

PSYCHOLOGICAL:
- ☐ Depression
- ☐ Anxiety
- ☐ Other Mental problem__________

OTHER:
- ☐ Fibromyalgia

Family Medical History (Please explain if any of these conditions have affected a blood relative)

☐ Cancer ☐ Breast Disease ☐ Heart disease ☐ Diabetes ☐ Bleeding problem ☐ Reaction to anesthesia

Medical Illnesses: (This applies to the patient. If yes, please explain)

EYES:
☐ Glaucoma
☐ Vision loss/blindness

STOMACH/INTESTINAL:
☐ GERD ☐ Ulcers
☐ Other:_______________________________

LUNGS/RESPIRATORY:
☐ Asthma
☐ Obstructive Sleep Apnea ☐ CPAP
☐ COPD/emphysema/chronic bronchitis
☐ Pneumonia
☐ Tuberculosis
☐ Other:________________________________

HEART:
☐ High blood pressure ☐ High cholesterol
☐ Heart murmurs ☐ Heart Valve Problem
☐ Irregular or rapid heart beat
☐ Coronary heart disease
☐ Congestive heart failure
☐ Heart attack year:__________________
☐ Implanted pacemaker or defibrillator
☐ Other:________________________________

NEUROLOGICAL:
☐ Stroke ☐ Seizures/Epilepsy
☐ TIA (transient ischemic attacks)
☐ Multiple Sclerosis
☐ Other:_________________________________

MUSCLE/JOINT:
☐ Arthritis
☐ Fractures:__________________________

URINARY/BLADDER PROBLEMS:
☐ Stress/urge incontinence
☐ Frequent urinary tract infections
☐ Gynecological problems
☐ Other:______________________________

ENDOCRINE DISORDERS:
☐ Thyroid disease (hyper/hypo)
☐ Diabetes mellitus
☐ Osteoporosis/Osteopenia

IMMUNE SYSTEM/INFECTIONS:
☐ AIDs or HIV positive
☐ Hepatitis ☐ Jaundice or liver disease

PSYCHOLOGICAL DISORDERS:
☐ Depression ☐ Anxiety
☐ Other:____________________________________

CANCER:
☐Breast ☐Lung ☐Thyroid ☐Prostate ☐Kidney
☐Brain ☐ Skin ☐Other:____________________

BLOOD DISORDERS:
☐History of blood clots (DVT or PE)
☐Coumadin Therapy ☐Aspirin ☐Plavix

How did you hear about ReGenesis Plastic Surgery and Skin Care Center?
☐ Internet search ☐ Doctor ☐ Friend ☐ Other __________________
☐ Television ☐ Magazine

Who can we thank for this referral? ___________________________

Completed by ____

Signature ____

Section below to be completed by physician

I have read & reviewed
Physician's Signature ____