THE AMERICAN SOCIETY FOR AESTHETIC PLASTIC SURGERY, INC.

Questionnaire: Breast Implant Illness Patient

Name: _____ **Date of Birth:** _____

Date: _____ **Height:** _____ **Weight:** _____

Reason implants were placed:
☐ Reconstruction (Cancer)
☐ Reconstruction (Asymmetry)
☐ Augmentation

Date that implants were placed: _____

Name of the implant manufacturer:
☐ Mentor
☐ Allergan/McGhan/Inamed/Natrelle
☐ Sientra/Silimed
☐ Other _____

Implant fill:
☐ Silicone
☐ Saline
☐ Both

Implant Shape:
☐ Round
☐ Shaped

Implant surface:
☐ Smooth
☐ Textured

Implant placement:
☐ IMF
☐ Axilla
☐ Areola
☐ Umbilicus

Were you happy with your initial implant placement? Yes ☐ No ☐
If not, please explain
_____
_____

Was pocket irrigation performed? Yes ☐ No ☐
If yes, with what:
☐ Betadine
☐ Antibiotic
☐ Other

Please check all symptoms that apply:

☐ Abdominal Gas
☐ Acid Reflux
☐ Anxiety/Depression/Panic Attacks
☐ Body Odor
☐ Chest Discomfort
☐ Chronic Pain
☐ Cognitive Dysfunction/Brain fog/Memory changes
☐ Cold/Discolored Limbs/Hands/Feet
☐ Dry Eyes/Declined Vision/Vision Disturbance
☐ Ear Ringing
☐ Fatigue
☐ Fever/Night Sweats
☐ Frequent Urination
☐ Fungal Infections
☐ Gout
☐ Hair Loss
☐ Headaches
☐ Hemorrhoids
☐ High Blood Pressure
☐ Intolerant to Heat/Cold
☐ Irregular Heartbeat
☐ Joint Pain
☐ Low Libido
☐ Menstrual Irregularities
☐ Muscle Pain/Weakness
☐ Numbness/Tingling in upper/lower extremities
☐ Pain/Burning sensation around implant/underarm
☐ Poor Sleep/Insomnia
☐ Rash/Dry Skin
☐ Rectal Pain
☐ Runny Nose
☐ Vertigo
☐ Weight Problems
☐ Other: _____

Had you had previous implant surgery? Yes ☐ No ☐
If so, please give dates, type of implants placed and reason for surgery:
_____
_____

How long after implant placement did your symptoms begin? _____

Please check the following boxes of any conditions you've been diagnosed with:

☐ Fibromyalgia
☐ Hashimoto's Thyroiditis
☐ Irritable Bowel Disease
☐ Endocrine Dysfunction
☐ Graves' Disease
☐ Inflammatory Bowel Disease
☐ Hypothyroidism
☐ Lyme Disease
☐ Vitamin D deficiency
☐ Other: _____

Did you have any of the above symptoms or diagnoses prior to your implant placement? If yes, please list:

_____
_____

Name of other physicians and dates seen regarding your symptoms?

Primary Care: _____

Infectious Disease: _____

Rheumatologist: _____

Neurologist: _____

Other: _____

Did you have any lab work or diagnostic studies performed?
If yes, please list: _____
_____

Have you had any abnormal laboratory results? Yes ☐ No ☐
If so, what were the results? _____
_____

Were medications or treatments prescribed? Yes ☐ No ☐
If so, please list them: _____
_____

Do you have other medical conditions unrelated to the symptoms listed above?
If so, please list them: _____
_____

Is there a family history of auto-immune or connective tissue diseases? If so, which family member(s) and what disease (s)?

_____
_____

Have you had a recent mammogram, Ultrasound, or MRI? Yes ☐ No ☐
If yes, what were the results?
_____
_____

Is there a family history of breast cancer? Yes ☐ No ☐
If yes, which family member(s)? _____
_____

Have you recently experienced any major life changes since breast implants were placed? (e.g. divorce, death in family, unemployment, household move, etc.) Yes ☐ No ☐

_____

Do you have any allergies to food? Yes ☐ No ☐
If yes, please list: _____
_____

Do you have any allergies to any medications? Yes ☐ No ☐
If yes, please list: _____
_____

Do you have any environmental allergies? Yes ☐ No ☐
If yes, please list: _____
_____

Do you have any tattoos? Yes ☐ No ☐
If yes, please select where:

☐ Arms
☐ Legs
☐ Torso