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plastic surgery + wellmed spa

Breast Implant Illness Questionnaire

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 _____
☐ unknown

Implant fill:
☐Silicone
☐Saline
☐Both
☐unknown

Implant Shape:
☐Round
☐Shaped
☐unknown

Implant surface:
☐Smooth
☐Textured
☐Unknown

Implant placement:
☐IMF
☐Axilla
☐Areola
☐ Umbilicus
☐ Mastectomy Incision
☐ Mastopexy incision

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
☐ unknown

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
☐ Other:_____
_____
_____

☐ 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

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 if you have any of the diagnoses below:

☐ 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 :

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

Please list any other information/studies/details regarding your BII symptoms.