Pre-operative Questionnaire:

Name: _____ Date of Birth: _____

Date: _____

When did you have implants placed?

Reason implants were placed:

- Reconstruction (Cancer)
- Reconstruction (Asymmetry)
- Augmentation

What was the name of the implant manufacturer?

- Mentor
- Allergen/McGhan/Inamed/Natrelle
- Sientra/Silimed
- Other:

How was the implant placed?

- Inframammary fold
- Axilla
- Areola
- Umbilicus
- Mastectomy incision

What was the implant fill?

- Silicone
- Saline
- Both

What was the implant shape?

- Round
- Shaped

What type of implant surface?

- Smooth
- Textured

Implant was placed:

- Above the muscle
- Below the muscle

Was pocket irrigation performed during your implant placement? Yes • No • Unsure •
If yes, what was used?

- Betadine
- Antibiotics
- Other

How satisfied were you with your initial implant placement?

- Very satisfied
- Satisfied
- Neither satisfied nor dissatisfied
- Dissatisfied
- Very dissatisfied

How satisfied were you with the information provided to you by your plastic surgeon about the risks associated with implants?

- Very satisfied
- Satisfied
- Neither satisfied nor dissatisfied
- Dissatisfied
- Very dissatisfied

How likely would you be to have implants placed again?

- Very likely
- Likely
- Unlikely
- Very unlikely

Since placement of your implants, how often have you felt:

	None of the time	Some of the time	All of the time
Pain in your breast area?	**1**	**2**	**3**
Tightness in your breast area?	**1**	**2**	**3**
Uncomfortable shifting of the implants during physical activity (e.g. running down stairs)?	**1**	**2**	**3**
Difficulty sleeping because of discomfort in your breast area?	**1**	**2**	**3**
Difficulty doing vigorous physical activities ?	**1**	**2**	**3**
Difficulty lifting or moving your arms?	**1**	**2**	**3**

Since placement of your implants, have you experienced any of the following symptoms which you believe to be caused by your implants?

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Abdominal bloating	1	2	3	4	5
Acid reflux	1	2	3	4	5
Anxiety/depression or panic attacks	1	2	3	4	5
Arthritis	1	2	3	4	5
Body Odor	1	2	3	4	5
Back Pain	1	2	3	4	5
Chest discomfort	1	2	3	4	5
Chronic pain	1	2	3	4	5
Cognitive dysfunction/brain fog	1	2	3	4	5

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Cold/discolored hands/feet	1	2	3	4	5
Dry eyes/worsening vision/vision disturbances	1	2	3	4	5
Ear ringing	1	2	3	4	5
Emotional Instability	1	2	3	4	5
Fatigue	1	2	3	4	5
Fever/night sweats	1	2	3	4	5
Food intolerance/food allergies	1	2	3	4	5
Frequent urination	1	2	3	4	5
Fungal infections	1	2	3	4	5

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Gout	1	2	3	4	5
Gastrointestinal Issues	1	2	3	4	5
Hair loss	1	2	3	4	5
Headaches	1	2	3	4	5
Hemorrhoids	1	2	3	4	5
High blood pressure	1	2	3	4	5
Intolerant to head/cold	1	2	3	4	5
Irregular heartbeat	1	2	3	4	5
Joint pain	1	2	3	4	5
Low libido	1	2	3	4	5

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Menstrual irregularities	1	2	3	4	5
Memory Loss	1	2	3	4	5
Migraines	1	2	3	4	5
Muscle pain/weakness	1	2	3	4	5
Numbness/tingling in upper/lower extremities	1	2	3	4	5
Pain/burning sensation around incision sites/underarm	1	2	3	4	5
Poor sleep/insomnia	1	2	3	4	5
Rash/dry skin	1	2	3	4	5
	None of the time	**A little of the time**	**Some of the time**	**Most of the time**	**All of the time**

Rectal pain	1	2	3	4	5
Runny nose	1	2	3	4	5
Shortness of breath	1	2	3	4	5
Thyroid disease	1	2	3	4	5
Vertigo	1	2	3	4	5
Weight Problems	1	2	3	4	5
Other:	1	2	3	4	5

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

How often did you experience each of these symptoms before placement of your implants ? For each symptom, please use the numerical score from above: 1 – none of the time, 2 - a little of the time, 3 - some of the time, 4 - most of the time, 5 - all of the time.

How long after implant placement did your symptoms begin?

Had you had previous implant surgery? Yes • No •

If so, please give the dates, types of implant, and reason for surgery:

Please indicate how much you agree or disagree with the following statements regarding your implant placement:

	Disagree	Somewhat agree	Definitely agree
Overall, the surgery was a good experience			
I have no regrets about having this surgery			
I am satisfied the results			
The outcome matched by expectations			

In the past week, how often have you felt:

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Confident in a social setting?	1	2	3	4	5
Good about yourself?	1	2	3	4	5
Confident in your clothes?	1	2	3	4	5
Of equal worth to other women?	1	2	3	4	5
Attractive?	1	2	3	4	5
Accepting of your body?	1	2	3	4	5

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Self-assured?	1	2	3	4	5
Confident about your body?	1	2	3	4	5
Self-confident?	1	2	3	4	5

Please check if you have any of the diagnoses below:

- Fibromyalgia
- Hashimoto's thyroiditis
- Irritable bowel syndrome
- Endocrine dysfunction
- Graves disease
- Inflammatory bowel disease
- Hypothyroidism
- Lyme disease
- Vitamin D deficiency
- Other:

Have you seen any other physicians regarding your symptoms?

Primary Care: _____

Infectious Disease: _____

Rheumatologist: _____

Neurologist: _____

Other: _____

Were any medications or treatments prescribed? Yes • No •

If so, please list them:

Do you have a family history of auto-immune or connective tissue disease? Yes • No •

If so, what type and which family members are affected?

Do you have a family history of breast cancer? Yes • No •

If yes, which members of your family?

Have you recently experiences any major life changes or events since breast implants were placed? (e.g. divorce, death in family, unemployment, household move, etc.)

Do you have allergies to any medications? Yes • No •

If yes, please list them here:

Do you have any food allergies? Yes • No •

If yes, please list them here:

Do you have any environmental allergies? Yes • No •

If yes, please list them here:

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

- Arms
- Legs
- Torso