

**SILICONE BREAST IMPLANT QUESTIONNAIRE**

Patient Name: \_\_\_\_\_

(Other last names since implants were placed? \_\_\_\_\_)

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

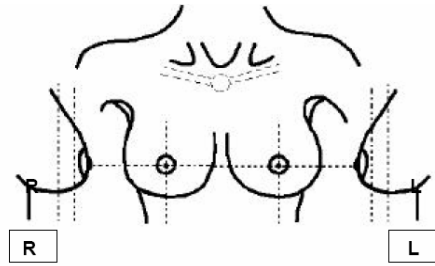
**IMPLANT HISTORY:**

Please complete for all current and prior implants. Please enter pertinent information for each set of implants in the column for that set of implants, if known. If unknown, put N/A.

**CLINICAL HISTORY**

Please enter a number for both **Left** and **Right**.  
(0 = none, 1 = mild, 2 = moderate, 3 = severe)

Change in Shape	<input type="checkbox"/> Yes	<input type="checkbox"/> No	L _____	R _____
Breast Hardness	L _____	R _____		
Breast Pain	L _____	R _____		
Skin Nodules (lumps) (Under the arms or in the breast)	L _____	R _____		



If you have any implants in now, have you had an **OPEN CAPSULOTOMY** (surgical) for current implants?  Yes  No  Don't Know

Left side? \_\_\_\_\_

Right side \_\_\_\_\_

If you have any implants in now, have you had a **CLOSED CAPSULOTOMY** (surgical) for current implants?  Yes  No  Don't Know

Left side? \_\_\_\_\_

Right side \_\_\_\_\_

(A closed capsulotomy is an office procedure during which the breast is forcefully massaged to soften the scar capsule that surrounds the implant.)

If you have implants in now, have either of you current implants suffered **TRAUMA**?  Yes  No  Don't Know

If so, which one(s): \_\_\_\_\_ when: \_\_\_\_\_

And how: \_\_\_\_\_

**SILICONT BREAST QUESTIONNAIRE (CONTINUED)**

Plan at this time: (Fill in number from list below) \_\_\_\_\_

1. Definitely leave implants in
2. Undecided
3. Defiantly remove implants, date and surgeon not yet chosen
4. Remove implants (if so, Date \_\_\_\_\_ Time \_\_\_\_\_ Surgeon \_\_\_\_\_)

Since your (first) implant(s) were placed

- Have you had any MAMMOGRAMS?  Yes  No  
 Have you had any breast ULTRASOUND examinations?  Yes  No  
 Have you had any breast MRI scans?  Yes  No

If so, where? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**CURRENT IMLANTS:**

- 0 = no implants in place at this time (removed)  
 1 = Single lumen, silicon gel  
 2 = double lumen, silicon gel inner cavity, saline outer cavity  
 3 = double lumen, silicon gel outer cavity, saline inner cavity  
 4 = saline implants

Names of some manufacturers:

- Dow Corning**    **Surgitek**    **Bioplasty**    **3m**    **Cox Uphoff**    **McGhan**  
**Heyer Schulte**    **3M/McGhan**    **Natural Y**    **Mentor**    **Baxter-Travanol**

	<b>First Set</b>	<b>Second Set (if applicable)</b>
Manufacturer	_____	_____
Style or Type	_____	_____
Date Placed	_____	_____
Date Removed	_____	_____
Reason Removed	_____	_____
Known Rupture?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Known Leak?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Textured or smooth?	_____	_____
Placed Under Muscle?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No