Is there any history of breast cancer in your family: _____ No _____ Yes

If yes, Relative: Mother: _____ Sister(s) _____ Other _____
Maternal Grandmother _____ Paternal Grandmother _____

Have you ever had radiation treatment to your breast or chest wall No_____ Yes_____
Explain: _____

Are you a current smoker? No _____ Yes _____ Packs/Day _____ Total years: _____
Do you drink alcohol? No _____ Yes _____ How much daily? _____
Do you have any allergies to medications? No _____ Yes _____ Explain: _____

Please indicate any previous, ongoing or planned therapy for breast cancer:
_____ Chemotherapy _____ Radiation Therapy
_____ Tamoxifen _____ Other Hormone therapy
_____ Other: _____

Please list any previous surgical procedures (not related to current breast diagnosis):

Procedure Date
_____
_____
_____
_____
_____

Please list current medications, vitamins, and herbal supplements used on a regular basis:

Medication or Compound Date & Schedule
_____
_____
_____
_____
_____

Please List any other medical conditions (such as heart attacks, high blood pressure, diabetes, blood clots, etc.):

Description:	Date of onset or age	Currently treated
_____	_____	No _____ Yes _____
_____	_____	No _____ Yes _____
_____	_____	No _____ Yes _____

What is your occupation? _____
Please indicate current employment status (choose only one):
_____ Employed greater than 32 hours/week
_____ Employed less than 32 hours/week
_____ Full time student
_____ Part time student
_____ Employed less than 32 hours and a student
_____ Homemaker
_____ On medical leave
_____ Disabled
_____ Unemployed and/or seeking work
_____ Retired
_____ Other: _____

Please choose on option that best describes your current level of activity:
_____ Fully active, able to carry on all usual activities without restrictions
_____ Restricted in physically strenuous activity, but can walk and is able to carry out light housework.
_____ Can walk and take care of self, but is unable to carry out any work activities. Up more than half a day.
_____ Needs some help taking care of yourself, spends more that half a day in bed or in a chair.
_____ Cannot take care of yourself at all and spends all of your time in a bed or chair.

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PLASTIC SURGERY

2361 HUNTINGDON PIKE, HUNTINGDON VALLEY PA 19006
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WWW.DRDIBELLO.COM

Name: _____ Date: _____

Height:_____ Weight: _____ Age: _____

Referring Physician : _____

Please list any recent biopsies, scans, x-rays, or other tests related to your present breast diagnosis:

Procedure *Date*

_____

_____

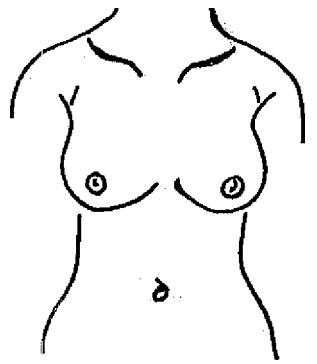
_____

_____

_____

Indicate the involved area(s) of your breast(s) or site(s) of previous breast surgery.

R L



Bra/Cup Size (e.g. 34B) _____ Has this changed in the last year: Y / N
Number of pregnancies: _____ Age at 1" menstrual period: _____
Number of children: _____ Age at 1" full-term pregnancy: _____
Able to breast feed: _____

Have you had a menstrual period within the last six months? _____Yes, Regular _____Yes, Irregular _____No

If you have not had a period within the last six months, please indicate why your periods have stopped:

____ Pregnancy and/or breast feeding
____ Hysterectomy, ovaries left in (Date:_____)
____ Hysterectomy, unsure about ovaries (Date:_____)
____ Chemotherapy, radiation, or hormonal therapy
_____ Natural menopause (Age: ____)
_____ Hysterectomy, both ovaries removed (Date: _____)
_____ Both ovaries removed, no hysterectomy (Date:_____)
_____ Other, please specify: _____

Are you currently using birth control pills? _____No _____Yes If yes, how many years? _____
Did you ever use hormones after menopause? _____ No _____Yes If yes, how many years? _____
Age at first Mammogram: _____ Number of mammograms to date: _____
Date of last Mammogram: _____ Result:_____

Have you been told that you have fibrocystic breasts?_____No ____ Yes
Have you had previous breast surgery(s)?: _____ No ____ Yes If Yes, please explain _____

Do you have any of the following symptom associated with the breast(s):

(please check)	No	Yes	Right	Left	Both
Breast pain	_____	_____	_____	_____	_____
Rashes under breasts	_____	_____	_____	_____	_____
Shoulder Straps grooving	_____	_____	_____	_____	_____
Neck Pain	_____	_____	_____	_____	_____
Upper back pain	_____	_____	_____	_____	_____
Lower back pain	_____	_____	_____	_____	_____
Absent or diminished nipple sensation	_____	_____	_____	_____	_____

Are any of these symptoms being treated? _____