Breast Implant Removal Questionnaire

Patient Name: ____ Date: ____________________

Please check all symptoms that you feel might be associated with your implants:

- ☐ Acid Reflux/GERD
- ☐ Acne
- ☐ Adrenal Fatigue
- ☐ Allergies
- ☐ Anxiety/Depression/Panic Attacks
- ☐ Asthma
- ☐ Autoimmune issues
- ☐ Brain Fog/Cognitive Dysfunction
- ☐ Breast Pain
- ☐ Capsular Contracture
- ☐ Chest Pain
- ☐ High Cholesterol
- ☐ Cough
- ☐ Dizziness/Vertigo
- ☐ Dry Eyes or Vision Issues
- ☐ Early Menopause or Menopause
- ☐ Symptoms
- ☐ Fatigue
- ☐ Fibromyalgia
- ☐ Flu Like Symptoms
- ☐ Food Intolerance
- ☐ Gastrointestinal Issues/IBS/Leaky Gut
- ☐ Hair Loss or Skin Issues
- ☐ Headaches/Migraines
- ☐ Heart Issues
- ☐ Heat/Cold Intolerance
- ☐ Hormonal Imbalance
- ☐ Immune Issues/Frequent Infections
- ☐ Implants Too Large
- ☐ Implant Rupture
- ☐ Inflammation
- ☐ Insomnia/Poor Sleep
- ☐ Irregular Periods
- ☐ Joint Pain/Arthritis
- ☐ Kidney/Bladder Problems
- ☐ Low Libido
- ☐ Lymph Node Swelling
- ☐ Metallic Taste
- ☐ Muscle Pain/Weakness
- ☐ Pain (Other Than Breast)
- ☐ Night Sweats/Fevers Numbness
- ☐ No Problems, Just Want Them Out
- ☐ Numbness/Tingling
- ☐ Osteoporosis
- ☐ Premature Aging
- ☐ Palpitations
- ☐ Rashes
- ☐ Restless Leg Syndrome
- ☐ Sinus Issues
- ☐ Sleep Apnea
- ☐ Shortness of Breath
- ☐ Difficulty Swallowing/Choking
- ☐ Tinnitus/Ringing in Ears
- ☐ Thyroid Issues (Hyperthyroidism, Hypothyroidism, Hashimoto's)
- ☐ Vertigo/Dizziness
- ☐ Urinary Tract Infections/Frequent
- ☐ Urination
- ☐ Vision Problems
- ☐ Weight Gain/Loss
- ☐ ____________________________________
- ☐ ____________________________________
- ☐ ____________________________________
- ☐ ____________________________________
- ☐ ____________________________________
- ☐ ____________________________________

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Implant Brand	Implant Material	Implant Position	Implant Texture
☐ Mentor ☐ Allergan/Inamed/McGhan ☐ Sientra ☐ Other ☐ Unknown	☐ Saline ☐ Silicone ☐ Other ☐ Unknown	☐ Above the Muscle ☐ Below the Muscle ☐ Unknown	☐ Smooth ☐ Textured ☐ Unknown

Incision Location	Implant Date (Most Recent)	Right Implant Size (cc's)	Left Implant Size (cc's)
☐ Peri-areolar (through the areola) ☐ Transaxillary (through the armpit) ☐ Inframammary (under the breast at the fold) ☐ Other ☐ Unknown			

Describe any other breast surgeries prior to your last breast surgery:
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____

____

Have you had a recent mammogram: ____

If yes, were there any abnormalities: ____

Do you have any family history of breast cancer: ______________________________________

If yes, relationship: ____