LAST NAME:_____FIRST NAME:_____M.I._____

CUSTOM BREAST HEALTH HISTORY/FITTER CONSULTATION

DATE OF SCANNING: _____

Certified Fitter Name and CFm License #_____

☐ **Physician Medical Records placed in patient file for proof of Certificate of Medical Necessity.**

==========

SURGERY : YEAR_____SIDE: RIGHT LEFT BILATERAL
LYMPH NODE REMOVAL: YES #_____ NO_____NOT SURE_____
( ) RADICAL ( ) MODIFIED ( ) PARTIAL ( ) LUMPECTOMY ( ) RECONSTRUCTION
( ) FAILED SURGICAL RECONSTRUCTION
( ) IMPLANT(S) ( ) IMPLANT REMOVAL ( ) BREAST REDUCTION ( ) PROPHYLACTIC

Do you have an open wound on your chest wall that would prohibit a fitting at this time?
( )YES ( )NO
Have you experienced difficulty with adjusting to the weight of silicone breast form? ( )YES ( )NO
Do you experience your silicone breast form shifting in your bra? ( )YES ( )NO
Do you experience pressure, sensitivity or pain on your chest wall or underarm due to weight of a silicone breast form? ( )YES ( )NO
Are you sensitive/allergic reaction to Silicone breast form? ( )YES ( )NO
Have you experienced changes in your chest wall due to radiation? ( )YES ( )NO
Do you find your silicone breast form is restricting you from physical activity? ( )YES ( )NO
In the past, has your silicone breast form caused you discomfort in your shoulder(s) and/or neck?
( )YES ( )NO
Do you feel you are not symmetric in appearance with an off the shelf silicone breast prosthesis?
( )YES ( )NO
Do you feel you will benefit or prefer a non-surgical, non-evasive option for symmetry restoration?
( )YES ( )NO
Do you have Lymphedema? ( )YES ( )NO
Do you experience pain from Keloid scars ( ) YES ( ) NO

FORM COMPLETED BY:

_____ _____ _____
X Signature X Print Name Date
RELATIONSHIP TO PATIENT: SELF_____ OTHER:_____

This form is reviewed for accuracy at each patient visit.

ORIG: 02/06/19
REV: 01/14/2020