BREAST HEALTH HISTORY/FITTER CONSULTATION

LAST :_____ **FIRST:**_____ **MI**_____
D.O.B.: MONTH_____ DAY_____ YEAR_____

Last Fitting Date: _____ Where:_____

FAMILY MEMBERS WITH BREAST CANCER

☐NONE ☐MOTHER ☐GRANDMOTHER ☐SISTER(S) ☐COUSIN(S) ☐AUNT(S) ☐DAUGHTER(S)

○ Physician Medical Records placed in patient file for confirmation of surgery.

○ IS THIS PATIENT EXPERIENCING HER FIRST VISIT WITH NEW SURGERY AND HAVING FIRST FITTING?
(No prior breast cancer or breast surgery) YES NO

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SURGERY 1: YEAR_____ SIDE: RIGHT LEFT BILATERAL
LYMPH NODE REMOVAL: YES #_____ NO_____ NOT SURE_____
( ) RADICAL ( ) MODIFIED ( ) PARTIAL ( ) LUMPECTOMY ( ) RECONSTRUCTION or FAILED RECONSTRUCTION
( ) IMPLANT(S) ( ) IMPLANT REMOVAL ( ) BREAST REDUCTION ( ) PROPHYLACTIC

SURGERY 2: YEAR_____ SIDE: RIGHT LEFT BILATERAL
LYMPH NODE REMOVAL: YES #_____ NO_____ NOT SURE_____
( ) RADICAL ( ) MODIFIED ( ) PARTIAL ( ) LUMPECTOMY ( ) RECONSTRUCTION or FAILED RECONSTRUCTION
( ) IMPLANT(S) ( ) IMPLANT REMOVAL ( ) BREAST REDUCTION ( ) PROPHYLACTIC

SURGERY 3: YEAR_____ SIDE: RIGHT LEFT BILATERAL
LYMPH NODE REMOVAL: YES #_____ NO_____ NOT SURE_____
( ) RADICAL ( ) MODIFIED ( ) PARTIAL ( ) LUMPECTOMY ( ) RECONSTRUCTION OR FAILED RECONSTRUCTION
( ) IMPLANT(S) ( ) IMPLANT REMOVAL ( ) BREAST REDUCTION ( ) PROPHYLACTIC

Does patient have an open wound on her chest wall that would prohibit a fitting at this time? YES NO

Is patient experiencing any fluid/drainage on the surgical site on this visit: ( ) YES ( ) NO
Does patient have a port? ( )Yes SIDE:_____ ( ) NO
Is patient currently undergoing radiation treatment? ( )YES ( )NO
Is patient currently undergoing chemotherapy treatment? ( )YES ( )NO
When did patient start treatments? _____ ( )NOT SURE
How many treatments have you had so far? _____ ( )NOT SURE
Experiencing hair loss? ( ) YES ( ) NO
Experiencing pain from Keloid scars ( ) YES ( ) NO

This form is reviewed for accuracy at each patient visit.

REV. 07/2018

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☐ At the time of surgery, was patient informed about the risk of developing Lymphedema or taught risk reduction methods? ( )YES ( )NO

☐ Has patient been diagnosed by a Physician with Lymphedema ( ) YES ( ) NO

( )Right Arm ( )Left Arm ( )Both ( )Elsewhere on body:_____

Has the patient been diagnosed and/or under treatment with any of the following:

☐ CURRENT WEIGHT_____WEIGHT **GAIN** lbs. How much since last fitting:_____
☐ CURRENT WEIGHT_____WEIGHT **LOSS** lbs. How much since last fitting:_____

☐ Arthritis: ( )Hands ( )Legs ( )Other

☐ ALLERGIES:_____

☐ Hepatitis Type: If YES, Please cirlcle type: A B C ( )NO

☐ Parkinson's

☐ Skin: Open Wounds ☐Bleeding ☐Rash ☐Allergies (Example: to Latex gloves)

☐ Skin: Swelling/Irritation/Breakdown/Pain/Redness:_____

☐ Diabetes ☐Shingles ☐Infection ☐Allergies Type:_____

☐ Heart Condition Pacemaker: ( ) YES ( ) NO

☐ Congestive Heart Failure (CHF): ( ) YES ( ) NO

☐ Poor Leg Circulation- Do you wear compression hosiery? ( ) YES ( ) NO

☐ Varicose Veins: ( ) YES ( ) NO

☐ Night Sweats

☐ Range of Motion Stiffness: ( ) YES ( ) NO

☐ Numbness ( ) YES ( ) NO Other Illness/Condition we should be aware of:

FORM COMPLETED BY:

_____

X Print Name
RELATIONSHIP TO PATIENT: SELF_____ OTHER:_____

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