

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

**BREAST RECONSTRUCTION QUESTIONNAIRE**

Location of Tumor:                      Right                      Left                      Bilateral

Date of Diagnosis: \_\_\_\_\_

Tumor Size: \_\_\_\_\_ cm.

- Tumor Type:    € Ductal Invasive  
                    € Ductal In-situ (DCIS)  
                    € Lobular Invasive  
                    € Lobular In-Situ (LCIS)  
                    € Other \_\_\_\_\_

Height: \_\_\_\_\_                      Weight: \_\_\_\_\_                      Bra Size: \_\_\_\_\_

Please list any family history of breast cancer:

| Relationship | Age of Diagnosis | Tumor Type (If Known) |
|--------------|------------------|-----------------------|
|              |                  |                       |
|              |                  |                       |
|              |                  |                       |

Do you plan on having children/more children?    €Yes    €No

Please list any history of breast surgery and radiation:  
\_\_\_\_\_  
\_\_\_\_\_

Family Physician: \_\_\_\_\_  
Surgical Oncologist: \_\_\_\_\_  
Medical Oncologist: \_\_\_\_\_