Health Questionnaire- Breast Cancer Recovery

Personal Details:

Name		Date	
Address:		Email	
		Date of birth	
		Weight	
		Height	

Surgery Details:

Date of surgery	
Type of surgery	
Lymphedema	Yes/No

Adjuvant Treatment:

Chemotherapy	Yes/No
Radiation Therapy	Yes/No
Date of last treatment	

Type of Reconstruction:

Implants	
FLAP	
Date of reconstruction	

Other details:

Any post-op pain?	Yes/No
if yes, where?	
How often do you experience this pain?	

Is there a factor which exacerbates the pain?	
Medications	
Any side effects	
Any other information	