Fox Valley Plastic Surgery, S.C.
2400 Witzel Avenue, Suite A
Oshkosh, WI 54904
920-233-1540
414-386-4625 E-Fax

www.fvpsurgery.com
2500 E Capitol Drive, Suite 1500
Appleton, WI 54911
920-358-1810
920-358-1819 Fax

Name: ______________________

DOB: ______________________

Breast Implant Illness Post Explantation Questionnaire

Date of Explantation:	<MRSurgery.SurgeryDate> for <MRSurgery.Reason>
Name of Implant Manufacturer:	☐ Mentor ☐ Allergan/McGhan/Inamed, Natrelle ☐ Sientra/Silimed ☐ Other:
Implant Fill:	☐ Silicone ☐ Saline ☐ Both
Implant Shape:	☐ Round ☐ Shaped
Implant Surface:	☐ Smooth ☐ Textured
Implant removed from:	☐ Above the muscle ☐ Below the muscle
With implant removal, did you have a capsulectomy? ☐ Yes ☐ No	
If yes, what type capsulectomy?	☐ Partial ☐ Total ☐ En Bloc
Was pocket irrigation performed?	☐ Yes ☐ No
If yes, with what:	☐ Betadine ☐ Antibiotic ☐ Other:
Indicate any other procedures performed at the time of explant:	☐ Implant exchange ☐ New implant placed under muscle ☐ Breast lift (mastopexy) ☐ Breast reduction ☐ Mesh or ADM ☐ Fat grafting
Was tissue sent for culture? ☐ Yes ☐ No	
If yes, please list results:	
Was tissue sent for pathology? ☐ Yes ☐ No	
If yes, please list results:	
Was fluid sent for cytology? ☐ Yes ☐ No	
If yes, please list results:	
Did you have DNA testing on your capsule? ☐ Yes ☐ No	
If yes, please list results:	
Did you have heavy metal testing on your capsule? ☐ Yes ☐ No	
If yes, please list results:	

Have you experienced improvement in any of the following symptoms since the implants were removed?

- ☐ Abdominal Gas
- ☐ Acid Reflux
- ☐ Anxiety/Depression/Panic Attacks
- ☐ Body Odor
- ☐ Chest Discomfort
- ☐ Chronic Pain
- ☐ Cognitive Dysfunctn/Brain Fog/Memory Changes
- ☐ Cold/Discolored Limbs/Hands/Feet
- ☐ Dry Eyes/Declined Vision/Vision Disturbance
- ☐ Ear Ringing
- ☐ Fatigue
- ☐ Fever/Night Sweats
- ☐ Frequent Urination
- ☐ Fungal Infections
- ☐ Gout
- ☐ Hair Loss
- ☐ Headaches
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Intolerant to Heat/Cold
- ☐ Irregular Heartbeat
- ☐ Joint Pain
- ☐ Low Libido
- ☐ Menstrual Irregularities
- ☐ Muscle Pain/Weakness
- ☐ Numbness/Tingling in upper/lower extremities
- ☐ Pain/Burning sensation at implant/underarm
- ☐ Poor Sleep/Insomnia
- ☐ Rash/Dry Skin
- ☐ Rectal Pain
- ☐ Runny Nose
- ☐ Vertigo
- ☐ Weight Problems
- ☐ Other: ______________________

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Which of the following symptoms do you still have after implant removal?

- ☐ Abdominal Gas
- ☐ Acid Reflux
- ☐ Anxiety/Depression/Panic Attacks
- ☐ Body Odor
- ☐ Chest Discomfort
- ☐ Chronic Pain
- ☐ Cognitive Dysfunctn/Brain Fog/Memory Changes
- ☐ Cold/Discolored Limbs/Hands/Feet
- ☐ Dry Eyes/Declined Vision/Vision Disturbance
- ☐ Ear Ringing
- ☐ Fatigue
- ☐ Fever/Night Sweats
- ☐ Frequent Urination
- ☐ Fungal Infections
- ☐ Gout
- ☐ Hair Loss
- ☐ Headaches
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Intolerant to Heat/Cold
- ☐ Irregular Heartbeat
- ☐ Joint Pain
- ☐ Low Libido
- ☐ Menstrual Irregularities
- ☐ Muscle Pain/Weakness
- ☐ Numbness/Tingling in upper/lower extremities
- ☐ Pain/Burning sensation at implant/underarm
- ☐ Poor Sleep/Insomnia
- ☐ Rash/Dry Skin
- ☐ Rectal Pain
- ☐ Runny Nose
- ☐ Vertigo
- ☐ Weight Problems
- ☐ Other: ______________________________

Names of physicians and dates seen following your explantation surgery? ☐ Yes ☐ No

If yes, please list: Primary Care:	
Infectious Disease:	
Rheumatologist:	
Neurologist:	
Other:	

Have you had any laboratory results since your surgery? ☐ Yes ☐ No

If yes, please list results:	

Have medications or treatments been prescribed since surgery? ☐ Yes ☐ No

If yes, please list:	

Signature: Today's Date: