Questionnaire: Post-Explantation Breast Implant Illness

Name: _______________________________ Date of Birth: _____________

Date: _______________ Date of Explantation: _____________

Name of the implant manufacturer:
☐ Mentor
☐ Allergan/McGhan/Inamed/Natrelle
☐ Sientra/Silimed
☐ Other ________

Implant fill:
☐ Silicone
☐ Saline
☐ Both

Implant Shape:
☐ Round
☐ Shaped

Implant surface:
☐ Smooth
☐ Textured

Implants removed from:
☐ Above the muscle
☐ Below the muscle

With implant removal did you have
☐ No capsulectomy
☐ Partial capsulectomy
☐ Total capsulectomy
☐ En Bloc capsulectomy

Antibiotic use with surgery? ________________________________

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 Dysfunction/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 around implant/underarm
☐ Poor Sleep/Insomnia
☐ Rash/Dry Skin
☐ Rectal Pain
☐ Runny Nose
☐ Vertigo
☐ Weight Problems
☐ Other: ______________________________
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 Dysfunction/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 around implant/underarm
- [ ] Poor Sleep/Insomnia
- [ ] Rash/Dry Skin
- [ ] Rectal Pain
- [ ] Runny Nose
- [ ] Vertigo
- [ ] Weight Problems
- [ ] Other: __________________________________________

Name of physicians and dates seen following your explantation surgery?

Primary Care: ______________________________

Infectious Disease: ______________________________

Rheumatologist: ______________________________

Neurologist: ______________________________

Other: ______________________________

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

If so, what were the results? ______________________________

Have medications or treatments been prescribed since surgery?  Yes  No

If so, please list them: ______________________________