THE AMERICAN SOCIETY FOR AESTHETIC PLASTIC SURGERY, INC.

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: _____