

Administrative Use _____ _____
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QUESTIONNAIRE
BREAST IMPLANT CARE STUDY

A. DEMOGRAPHICS AND LIFESTYLE

1. Patient name _____
2. Date of birth: (mm/dd/year) _____
3. What do you consider to be your race/ ethnicity?

Caucasian	Yes / No
Spanish or Hispanic descent?	Yes / No
African American	Yes / No
East Asian or Pacific Islander	Yes / No
American Indian, Aleutian, Eskimo	Yes / No
Southwest Asian	Yes / No
Not Known	Yes / No
Other _____	Yes / No
4. What is your marital status?

<input type="checkbox"/> SINGLE	<input type="checkbox"/> MARRIED	<input type="checkbox"/> PARTNERED
<input type="checkbox"/> DIVORCED	<input type="checkbox"/> WIDOWED	<input type="checkbox"/> SEPARATED
5. Who lives at home with you? _____

6. What is your highest level of schooling?
 - Graduate/ Professional
 - College
 - Bachelor's degree
 - High School
 - Junior high school
7. What is your sexual orientation?

<input type="checkbox"/> HETEROSEXUAL	<input type="checkbox"/> HOMOSEXUAL
<input type="checkbox"/> BISEXUAL	<input type="checkbox"/> NOT SURE
8. Which statement best describes your current alcohol use?
 - Never drink alcohol
 - Rarely drink (< once a month)
 - Few drinks a month
 - Few drinks each week
 - At least one drink most days
9. Which statement best describes your past alcohol use?
 - Never drink alcohol
 - Rarely drink (< once a month)
 - Few drinks a month
 - Few drinks each week
 - At least one drink most days

10. Have you ever smoked? Yes / No
If yes,
- When have you ever smoked?

<input type="checkbox"/> IN THE PAST	<input type="checkbox"/> CURRENTLY	<input type="checkbox"/> SOCIALLY
--------------------------------------	------------------------------------	-----------------------------------

 - Year you started smoking? _____
 - Year you stopped smoking? _____
 - Number of packs/day? < 1 1-2 >2
11. Do you use recreational drugs? Yes / No
If yes, what type _____
Frequency _____

B. GENERAL MEDICAL INFORMATION

12. What is your height? (feet and inches) _____
13. What is your current weight? (pounds) _____
14. What medications do you take? (Please include hormone replacement, birth control pills, over the counter medications, vitamins and herbs) _____

15. Please list and date any major illnesses or injuries **not** related to the breast (i.e. fibromyalgia, systemic lupus erythematosus etc...) _____

16. Please list and indicate the date of any surgical procedure **not** related to the breast (i.e. hysterectomy, appendectomy) _____

17. Please list and date any previous breast procedure, biopsy or treatment that does not include an implant-related operation

DATE	PROCEDURE	RIGHT/ LEFT BREAST	RESULT
18. Have you ever taken medicine for depression, anxiety, or a psychiatric condition? Yes / No

QUESTIONNAIRE
BREAST IMPLANT CARE STUDY

B. GENERAL MEDICAL INFORMATION (continued)

19. Have you undergone psychotherapy or counseling by a physician or psychiatrist?..... Yes / No

20. Have you ever been hospitalized for psychiatric reasons?.....Yes / No

*If you have never had a full-term pregnancy, skip to **Question # 25.***

21. Your age at first full-term pregnancy _____

22. How many children have you had? _____

23. Did you breast feed?.....Yes / No

24. Did you have implants during the time that you breastfed?..... Yes / No

C. BREAST IMPLANT AND RELATED INFORMATION

25. What is your bra cup size?

- < A
- A
- B
- C
- D
- >D

26. What is your bra band size in inches?

- < 32
- 34
- 36
- 38
- > 38

27. How long did you consider breast augmentation before having your first consultation? (*indicate number of years or months*) _____

28. What was your reason(s) for augmentation, or for what reason(s) are you considering the procedure? (*check any that apply*)

- LOOK BETTER WITHOUT CLOTHES
- LOOK BETTER IN CLOTHES
- IMPROVE BREAST APPEARANCE FOLLOWING PREGNANCY
- PLEASE A SIGNIFICANT OTHER
- CORRECT SAGGING
- HAVE LARGER BREASTS
- HAVE CLEAVAGE
- FIX SHAPE CONCERNS

*If you have not undergone breast augmentation yet, but are considering the procedure, please skip to **Question # 39.***

29. How long did you consider breast augmentation before undergoing your first augmentation procedure? (*indicate number of years or months*) _____

30. What information did you receive or use before your augmentation and did you find it helpful?

1= USELESS; 5= VERY HELPFUL

SCORE

- Independent website _____
- Discussion with surgeon _____
- Discussion with surgeon's staff _____
- Professional society website _____
- Friends _____
- Patient education brochure _____
- Online community _____
- Video presentation _____
- Implant manufacturer's information _____
- FDA booklet _____
- Other _____

31. Who or what influenced the type of implant used (silicone or saline)?

- Surgeon
- My own decision
- Surgeon and myself together
- Knew someone with implants
- Other _____

32. Please rate your satisfaction with your breasts before and after augmentation on a scale of 1 to 5. (*1= least happy, 5 = most happy*)

BEFORE AUGMENTATION

AFTER AUGMENTATION

Size _____

Size _____

Shape _____

Shape _____

Softness _____

Softness _____

Overall _____

Overall _____

33. If you could go back in time, would you have your breasts augmented again?.....Yes / No / Not sure *Why or why not?* _____

34. Would you recommend breast augmentation to a friend or family member? Yes / No / Not sure *Please explain* _____

Administrative Use

QUESTIONNAIRE
BREAST IMPLANT CARE STUDY

D. BREAST EXAMINATION AND IMAGING INFORMATION
(continued)

- 42. Have your breasts been imaged since your implant surgery? Yes / No / Not sure
- 43. Was your imaging technician aware that you had implants? Yes / No / Not sure
- 44. Was special care taken in handling your implants during imaging? Yes / No / Not sure
- 45. Have you ever worried that your implants popped during imaging? Yes / No / Not sure
- 46. Are you afraid of getting your implants imaged?
..... Yes / No / Not sure
- 47. Do you perform implant massage?Yes / No
- If yes, how often?
 - Several times a week
 - Weekly
 - Monthly
 - Seldom
 - Never

E. BREAST IMPLANT FOLLOW UP

- 48. Did your surgeon recommend that you return for routine checkups after your procedure?
..... Yes / No / Not sure
- If yes, how often?
 - Only shortly after the operation
 - Twice a year
 - Yearly
 - Only if I have a problem
 - Other _____
- 49. Did your surgeon recommend specific radiology follow up for your implants, independent of breast cancer screening?..... Yes / No / Not sure
- If yes, which tests? _____
- If yes, how often?
 - Twice a year
 - Yearly
 - Only if I have a problem
 - Other _____
- 50. Have you seen your breast implant surgeon for any breast implant follow up? Yes / No / Not sure
- If yes, how often?
 - Only shortly after the initial operation
 - Several times during the first year following the operation
 - Yearly
 - Only if I have a problem
 - Other _____

- 51. Have you utilized a doctor other than your surgeon for breast implant follow up?Yes / No
- If yes, what is their specialty? _____

- How often do you see them for your implants?
 - Only shortly after the operation
 - Twice a year
 - Yearly
 - Only if I have a problem
 - Other _____
- 52. If you have not seen a health care provider for implant follow up, what is the reason you have not done so? *(check any that apply)*
 - I have not had a problem
 - I do not consider it important to do so
 - I am concerned about the cost
 - I do not have health and/or implant insurance
 - I am worried there is a problem
 - I forgot the health care provider/ doctor's name
 - No time / scheduling conflicts
 - Other _____
- 53. If you never visited your surgeon after the initial recovery period, do you wish that you had?
..... Yes / No / Not sure
- 54. Would you see your implant surgeon yearly if there was an incentive for you to return?
..... Yes / No / Not sure
- 55. Do you presently have concerns about the condition or integrity of your implants?..... Yes / No / Not sure
- 56. Do you have concerns that the softness of your breast(s) is/are changing?..... Yes / No / Not sure
- 57. Do you feel that your implants have shifted position since your recovery period?..... Yes / No / Not sure
- 58. Are there any issues or concerns you have about your implants , your breasts that you would like to mention?

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**QUESTIONNAIRE
BREAST IMPLANT CARE STUDY**

F. BREAST SURGERY HISTORY

59. Initial implant surgery information

- What was the date of your first implant surgery? (mm/yyyy) _____
- What was your weight (in lbs.) at the time of implant surgery? _____
- How old were you at initial implant? (years) _____
- City, State where surgery occurred? _____
- Was your surgeon boarded-certified in either cosmetic or plastic surgery? Yes / No / Not sure
- If not, what was the specialty area of your implant surgeon? _____

60. Details of **Breast Procedures** and **Initial Implant Surgery (if applicable)**. Please fill out the following Table as best as you are able.

Details	Please check each box that applies for Sections (a) thru (i)
a. Breast procedure(s) other than implant surgery	<input type="checkbox"/> Breast lift <input type="checkbox"/> Mastectomy (partial or complete) <input type="checkbox"/> Breast biopsy <input type="checkbox"/> Breast reduction <input type="checkbox"/> Placement of tissue expander <input type="checkbox"/> Removal of tissue expander <input type="checkbox"/> Breast needle biopsy <input type="checkbox"/> Breast implant only <input type="checkbox"/> Other
b. Implant Type	<input type="checkbox"/> Saline <input type="checkbox"/> Silicone <input type="checkbox"/> Double lumen (gel and saline) <input type="checkbox"/> Not sure <input type="checkbox"/> Other
c. Manufacturer	<input type="checkbox"/> Mentor <input type="checkbox"/> McGhan <input type="checkbox"/> Not sure <input type="checkbox"/> Other
d. Shape of implant	<input type="checkbox"/> Round <input type="checkbox"/> Contoured (teardrop or anatomical) <input type="checkbox"/> Not sure
e. Surface of implant	<input type="checkbox"/> Smooth <input type="checkbox"/> Textured <input type="checkbox"/> Polyurethane <input type="checkbox"/> Not sure
f. Position of implant	<input type="checkbox"/> Under muscle <input type="checkbox"/> On top of the muscle <input type="checkbox"/> Not sure
g. Location of scar	<input type="checkbox"/> Under breast fold <input type="checkbox"/> In or around the nipple <input type="checkbox"/> Belly button <input type="checkbox"/> Armpit <input type="checkbox"/> Not sure
h. Serial/ Lot number	_____ <input type="checkbox"/> Do not know
i. Other cosmetic procedure(s)	<input type="checkbox"/> Tummy tuck <input type="checkbox"/> Face lift <input type="checkbox"/> Eye lid surgery <input type="checkbox"/> Liposuction <input type="checkbox"/> Other

Comments: _____

**QUESTIONNAIRE
BREAST IMPLANT CARE STUDY**

F. BREAST SURGERY HISTORY (continued)

61. Have you undergone revision surgery since your first implants were placed? Yes / No / Not sure
- If yes, go to **Question # 62** and fill out the Table as best as you are able. If you have had more than one revision surgery, use one Table for each procedure (**Questions 62 thru 65**). If you need more room, please copy a Table and add on.
 - If no, skip to **Question # 66**.

62. **Revision Surgery #1** was performed on *mm/yyyy* _____ on theLeft / Right / Both breasts / Not sure

Details of Revision	Please check each box that applies for Sections (a) thru (l)
a. Breast procedure(s) or revision(s)	<input type="checkbox"/> Breast lift <input type="checkbox"/> Mastectomy (partial or complete) <input type="checkbox"/> Breast biopsy <input type="checkbox"/> Breast reduction <input type="checkbox"/> Placement of tissue expander <input type="checkbox"/> Removal of tissue expander <input type="checkbox"/> Breast needle biopsy <input type="checkbox"/> Other
b. Capsule surgery	<input type="checkbox"/> Release or removal of capsule around implant (capsulotomy, capsulorrhaphy, capsulectomy) <input type="checkbox"/> Other
c. Scar surgery	<input type="checkbox"/> Revision of skin scars <input type="checkbox"/> Other
d. Implant surgery	<input type="checkbox"/> Nothing was done to the implant(s) <input type="checkbox"/> Remove saline implant; replace with silicone implant <input type="checkbox"/> Removal of implant only <input type="checkbox"/> Remove silicone implant; replace with saline implant <input type="checkbox"/> Implant removed and replaced, not sure what type <input type="checkbox"/> Remove implant; replace with same type of implant
e. Implant Size	<input type="checkbox"/> Nothing was done to the implant(s) <input type="checkbox"/> Remove implant; replaced with larger implant <input type="checkbox"/> Removal of implant only <input type="checkbox"/> Remove implant; replaced with smaller implant <input type="checkbox"/> Not sure <input type="checkbox"/> Remove implant; replaced with same size implant
f. Location of scar	<input type="checkbox"/> Under breast fold <input type="checkbox"/> In or around the nipple <input type="checkbox"/> Belly button <input type="checkbox"/> Armpit <input type="checkbox"/> Not sure
g. Implant repositioned	<input type="checkbox"/> Under muscle <input type="checkbox"/> On top of the muscle <input type="checkbox"/> Not sure
h. Manufacturer	<input type="checkbox"/> Mentor <input type="checkbox"/> McGhan <input type="checkbox"/> Not sure <input type="checkbox"/> Other
i. Shape of implant	<input type="checkbox"/> Round <input type="checkbox"/> Contoured (teardrop or anatomical) <input type="checkbox"/> Not sure
j. Surface of implant	<input type="checkbox"/> Smooth <input type="checkbox"/> Textured <input type="checkbox"/> Polyurethane <input type="checkbox"/> Not sure
k. Serial/ Lot number	_____ <input type="checkbox"/> Do not know
l. Other cosmetic procedure(s)	<input type="checkbox"/> Tummy tuck <input type="checkbox"/> Face lift <input type="checkbox"/> Eye lid surgery <input type="checkbox"/> Liposuction <input type="checkbox"/> Other

Comments: _____

Administrative Use _____

**QUESTIONNAIRE
BREAST IMPLANT CARE STUDY**

F. BREAST SURGERY HISTORY (continued)

63. Revision Surgery #2 was performed on mm/yyyy _____ on theLeft / Right / Both breasts / Not sure

Details of Revision	Please check each box that applies for Sections (a) thru (l)
a. Breast procedure(s) or revision(s)	<input type="checkbox"/> Breast lift <input type="checkbox"/> Mastectomy (partial or complete) <input type="checkbox"/> Breast biopsy <input type="checkbox"/> Breast reduction <input type="checkbox"/> Placement of tissue expander <input type="checkbox"/> Removal of tissue expander <input type="checkbox"/> Breast needle biopsy <input type="checkbox"/> Other
b. Capsule surgery	<input type="checkbox"/> Release or removal of capsule around implant (capsulotomy, capsulorrhaphy, capsulectomy) <input type="checkbox"/> Other
c. Scar surgery	<input type="checkbox"/> Revision of skin scars <input type="checkbox"/> Other
d. Implant surgery	<input type="checkbox"/> Nothing was done to the implant(s) <input type="checkbox"/> Remove saline implant; replace with silicone implant <input type="checkbox"/> Removal of implant only <input type="checkbox"/> Remove silicone implant; replace with saline implant <input type="checkbox"/> Implant removed and replaced, not sure what type <input type="checkbox"/> Remove implant; replace with same type of implant
e. Implant Size	<input type="checkbox"/> Nothing was done to the implant(s) <input type="checkbox"/> Remove implant; replaced with larger implant <input type="checkbox"/> Removal of implant only <input type="checkbox"/> Remove implant; replaced with smaller implant <input type="checkbox"/> Not sure <input type="checkbox"/> Remove implant; replaced with same size implant
f. Location of scar	<input type="checkbox"/> Under breast fold <input type="checkbox"/> In or around the nipple <input type="checkbox"/> Belly button <input type="checkbox"/> Armpit <input type="checkbox"/> Not sure
g. Implant repositioned	<input type="checkbox"/> Under muscle <input type="checkbox"/> On top of the muscle <input type="checkbox"/> Not sure
h. Manufacturer	<input type="checkbox"/> Mentor <input type="checkbox"/> McGhan <input type="checkbox"/> Not sure <input type="checkbox"/> Other
i. Shape of implant	<input type="checkbox"/> Round <input type="checkbox"/> Contoured (teardrop or anatomical) <input type="checkbox"/> Not sure
j. Surface of implant	<input type="checkbox"/> Smooth <input type="checkbox"/> Textured <input type="checkbox"/> Polyurethane <input type="checkbox"/> Not sure
k. Serial/ Lot number	_____ <input type="checkbox"/> Do not know
l. Other cosmetic procedure(s)	<input type="checkbox"/> Tummy tuck <input type="checkbox"/> Face lift <input type="checkbox"/> Eye lid surgery <input type="checkbox"/> Liposuction <input type="checkbox"/> Other

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**QUESTIONNAIRE
BREAST IMPLANT CARE STUDY**

F. BREAST SURGERY HISTORY (continued)

64. **Revision Surgery #3** was performed on *mm/yyyy* _____ on theLeft / Right / Both breasts / Not sure

Details of Revision	Please check each box that applies for Sections (a) thru (l)
a. Breast procedure(s) or revision(s)	<input type="checkbox"/> Breast lift <input type="checkbox"/> Mastectomy (partial or complete) <input type="checkbox"/> Breast biopsy <input type="checkbox"/> Breast reduction <input type="checkbox"/> Placement of tissue expander <input type="checkbox"/> Removal of tissue expander <input type="checkbox"/> Breast needle biopsy <input type="checkbox"/> Other
b. Capsule surgery	<input type="checkbox"/> Release or removal of capsule around implant (capsulotomy, capsulorrhaphy, capsulectomy) <input type="checkbox"/> Other
c. Scar surgery	<input type="checkbox"/> Revision of skin scars <input type="checkbox"/> Other
d. Implant surgery	<input type="checkbox"/> Nothing was done to the implant(s) <input type="checkbox"/> Remove saline implant; replace with silicone implant <input type="checkbox"/> Removal of implant only <input type="checkbox"/> Remove silicone implant; replace with saline implant <input type="checkbox"/> Implant removed and replaced, not sure what type <input type="checkbox"/> Remove implant; replace with same type of implant
e. Implant Size	<input type="checkbox"/> Nothing was done to the implant(s) <input type="checkbox"/> Remove implant; replaced with larger implant <input type="checkbox"/> Removal of implant only <input type="checkbox"/> Remove implant; replaced with smaller implant <input type="checkbox"/> Not sure <input type="checkbox"/> Remove implant; replaced with same size implant
f. Location of scar	<input type="checkbox"/> Under breast fold <input type="checkbox"/> In or around the nipple <input type="checkbox"/> Belly button <input type="checkbox"/> Armpit <input type="checkbox"/> Not sure
g. Implant repositioned	<input type="checkbox"/> Under muscle <input type="checkbox"/> On top of the muscle <input type="checkbox"/> Not sure
h. Manufacturer	<input type="checkbox"/> Mentor <input type="checkbox"/> McGhan <input type="checkbox"/> Not sure <input type="checkbox"/> Other
i. Shape of implant	<input type="checkbox"/> Round <input type="checkbox"/> Contoured (teardrop or anatomical) <input type="checkbox"/> Not sure
j. Surface of implant	<input type="checkbox"/> Smooth <input type="checkbox"/> Textured <input type="checkbox"/> Polyurethane <input type="checkbox"/> Not sure
k. Serial/ Lot number	_____ <input type="checkbox"/> Do not know
l. Other cosmetic procedure(s)	<input type="checkbox"/> Tummy tuck <input type="checkbox"/> Face lift <input type="checkbox"/> Eye lid surgery <input type="checkbox"/> Liposuction <input type="checkbox"/> Other

Comments:

**QUESTIONNAIRE
BREAST IMPLANT CARE STUDY**

F. BREAST SURGERY HISTORY (continued)

65. **Revision Surgery #4** was performed on *mm/yyyy* _____ on theLeft / Right / Both breasts / Not sure

Details of Revision	Please check each box that applies for Sections (a) thru (l)
a. Breast procedure(s) or revision(s)	<input type="checkbox"/> Breast lift <input type="checkbox"/> Mastectomy (partial or complete) <input type="checkbox"/> Breast biopsy <input type="checkbox"/> Breast reduction <input type="checkbox"/> Placement of tissue expander <input type="checkbox"/> Removal of tissue expander <input type="checkbox"/> Breast needle biopsy <input type="checkbox"/> Other
b. Capsule surgery	<input type="checkbox"/> Release or removal of capsule around implant (capsulotomy, capsulorrhaphy, capsulectomy) <input type="checkbox"/> Other
c. Scar surgery	<input type="checkbox"/> Revision of skin scars <input type="checkbox"/> Other
d. Implant surgery	<input type="checkbox"/> Nothing was done to the implant(s) <input type="checkbox"/> Remove saline implant; replace with silicone implant <input type="checkbox"/> Removal of implant only <input type="checkbox"/> Remove silicone implant; replace with saline implant <input type="checkbox"/> Implant removed and replaced, not sure what type <input type="checkbox"/> Remove implant; replace with same type of implant
e. Implant Size	<input type="checkbox"/> Nothing was done to the implant(s) <input type="checkbox"/> Remove implant; replaced with larger implant <input type="checkbox"/> Removal of implant only <input type="checkbox"/> Remove implant; replaced with smaller implant <input type="checkbox"/> Not sure <input type="checkbox"/> Remove implant; replaced with same size implant
f. Location of scar	<input type="checkbox"/> Under breast fold <input type="checkbox"/> In or around the nipple <input type="checkbox"/> Belly button <input type="checkbox"/> Armpit <input type="checkbox"/> Not sure
g. Implant repositioned	<input type="checkbox"/> Under muscle <input type="checkbox"/> On top of the muscle <input type="checkbox"/> Not sure
h. Manufacturer	<input type="checkbox"/> Mentor <input type="checkbox"/> McGhan <input type="checkbox"/> Not sure <input type="checkbox"/> Other
i. Shape of implant	<input type="checkbox"/> Round <input type="checkbox"/> Contoured (teardrop or anatomical) <input type="checkbox"/> Not sure
j. Surface of implant	<input type="checkbox"/> Smooth <input type="checkbox"/> Textured <input type="checkbox"/> Polyurethane <input type="checkbox"/> Not sure
k. Serial/ Lot number	_____ <input type="checkbox"/> Do not know
l. Other cosmetic procedure(s)	<input type="checkbox"/> Tummy tuck <input type="checkbox"/> Face lift <input type="checkbox"/> Eye lid surgery <input type="checkbox"/> Liposuction <input type="checkbox"/> Other

Comments:

**QUESTIONNAIRE
BREAST IMPLANT CARE STUDY**

G. BREAST IMPLANT PROBLEMS (continued)

66. Have you ever experienced a problem or complication associated with your breast implant surgery? Yes / No / Not sure
- If yes, please indicate and rate the severity of the problem 1 thru 5; 1 = minor problem, 5 = severe problem

PROBLEM OR COMPLICATION	CHECK IF YOU EXPERIENCED PROBLEM	PROBLEM SEVERITY; 1 THRU 5	APPROXIMATE DATE OF ONSET (MM/YYYY)	INTERVENTION REQUIRED? CHECK IF "YES"	AFFECTED BREAST(S): LEFT, RIGHT, OR BOTH
ASYMMETRIC BREASTS	<input type="checkbox"/>			<input type="checkbox"/>	
BLEEDING REQUIRING SURGERY	<input type="checkbox"/>			<input type="checkbox"/>	
BREAST TISSUE THINNING	<input type="checkbox"/>			<input type="checkbox"/>	
BREAST LUMP NON-CANCER	<input type="checkbox"/>			<input type="checkbox"/>	
BREAST CANCER	<input type="checkbox"/>			<input type="checkbox"/>	
BREAST PAIN/ BURNING	<input type="checkbox"/>			<input type="checkbox"/>	
BREASTFEEDING DIFFICULTY	<input type="checkbox"/>			<input type="checkbox"/>	
CALCIUM DEPOSIT AT IMPLANT	<input type="checkbox"/>			<input type="checkbox"/>	
CAPSULAR CONTRACTURE	<input type="checkbox"/>			<input type="checkbox"/>	
DELAYED HEALING	<input type="checkbox"/>			<input type="checkbox"/>	
DRESSING IRRITATION	<input type="checkbox"/>			<input type="checkbox"/>	
FLUID COLLECTION AROUND IMPLANT (SEROMA)	<input type="checkbox"/>			<input type="checkbox"/>	
GRANULOMA	<input type="checkbox"/>			<input type="checkbox"/>	
IMPLANT DISPLACEMENT, MOVED OR MIGRATED TO DIFFERENT POSITION	<input type="checkbox"/>			<input type="checkbox"/>	
IMPLANT POORLY POSITIONED	<input type="checkbox"/>			<input type="checkbox"/>	
IMPLANT EXTRUSION	<input type="checkbox"/>			<input type="checkbox"/>	
IMPLANT RUPTURE / DEFLATION	<input type="checkbox"/>			<input type="checkbox"/>	
INFECTION	<input type="checkbox"/>			<input type="checkbox"/>	
LACTATION	<input type="checkbox"/>			<input type="checkbox"/>	
LYMPH NODE ENLARGEMENT	<input type="checkbox"/>			<input type="checkbox"/>	
NIPPLE SENSATION CHANGE (TEMPORARY)	<input type="checkbox"/>			<input type="checkbox"/>	
NIPPLE SENSATION CHANGE (PERMANENT)	<input type="checkbox"/>			<input type="checkbox"/>	
SAGGING	<input type="checkbox"/>			<input type="checkbox"/>	
SCARRING	<input type="checkbox"/>			<input type="checkbox"/>	
SHAPE CHANGE	<input type="checkbox"/>			<input type="checkbox"/>	
SIZE TOO BIG	<input type="checkbox"/>			<input type="checkbox"/>	
SIZE TOO SMALL	<input type="checkbox"/>			<input type="checkbox"/>	
SYNMASTIA (UNIBREAST)	<input type="checkbox"/>			<input type="checkbox"/>	
TISSUE NECROSIS	<input type="checkbox"/>			<input type="checkbox"/>	
WRINKLING OR RIPPLING OF SKIN OVER IMPLANT	<input type="checkbox"/>			<input type="checkbox"/>	
UNSATISFACTORY RESULT	<input type="checkbox"/>			<input type="checkbox"/>	
OTHER (PLEASE SPECIFY)	<input type="checkbox"/>			<input type="checkbox"/>	

