

AUGMENTATION / MASTOPEXY / REDUCTION HISTORY

Name: _____ Date: _____

What is the reason of your visit today? _____

Is there a family history of this breast condition? _____

What is your Height: _____ Weight: _____ Age?: _____

What size bra do you currently wear? _____ Size Preference: _____

What age did you begin to menstruate? _____ Are your periods regular? _____

Do your breasts change during your menstrual cycle? _____ How? _____

How many times have you been pregnant? _____ Children _____ Ages _____

Did your breast change with the pregnancy? _____ How? _____

Did you breast feed your children? _____ How long? _____

Do you anticipate future pregnancies? _____

If so, do you plan on breast feeding? _____

Has anyone in your family had breast disease? _____

If so, please explain: _____

Do you have any personal history of breast disease, masses, or surgery? _____

Lumps _____ Discharge _____ Pain _____ Infections _____

If so, please explain: _____

When was your last Mammogram? _____

Do you do routine breast exams of yourself? _____ How often? _____

What medications are you currently taking? _____

Please see reverse side

Why are you thinking about having this surgery? _____

Are you familiar with the surgical procedures that you are considering? _____

Do you know people who have had this surgery? _____

Have you had previous cosmetic surgery? _____

If so, what and when: _____

What would you consider to be your general health? _____

Is there anything you feel like we need to know considering your medical history? _____

BREAST REDUCTION PATIENTS ONLY

Please indicate which of the following symptoms you have experience:

Shoulder pain _____ Breast Pain _____ Shoulder grooving _____

Neck pain _____ Rash under breast _____ Back pain _____

Shortness of breath _____ Limitation of physical activities _____

If so, please explain: _____

Other symptoms: _____

Have you seen any other doctors for treatment of any of these symptoms? _____

Who and When: _____

Thank you