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Aesthetic & Reconstructive Surgery

BREAST SURGERY HISTORY FORM

Name: _____ Date: _____

1. What is your particular breast problem? _____

2. Does this run in female members of your family? Yes No
Current Height: _____ Weight: _____ lbs
3. What size bra do you wear? _____ Padded _____ Unpadded _____
4. **What is your DESIRED breast size?** _____
5. How many children do you have? _____ What are their ages? _____
6. Did you breast feed? _____ Bottle feed? _____ Out of choice? Yes No
7. Did your breasts change size with pregnancy? Yes No If so, how much (bra size) _____
8. Have you ever had any breast diseases or breast tumors? Yes No Explain: _____
9. Has anyone in your family ever had breast diseases or breast tumors? Yes No
If yes, please explain _____
10. Has any doctor told you that you have any breast diseases or lumps recently? Yes No
If yes, please explain _____
11. Have you had a mammogram (breast x-ray) in the past? Yes No
If yes, please give the date and results of your last test _____

12. Have you ever had a breast reduction, enlargement, or lifting? Yes No
If yes, please explain (type, date, doctor) _____
13. Have you ever had any of the following breast problems?

<input type="checkbox"/> Nipple discharge	<input type="checkbox"/> Breast lumps or breast cysts
<input type="checkbox"/> Breast trauma	<input type="checkbox"/> Breast infection (Mastitis)
<input type="checkbox"/> Inverted nipples	<input type="checkbox"/> Breast pain and/or swelling
14. Are you taking birth control pills (or receiving estrogen shots)? Yes No
15. If you were treated for breast cancer, did you receive chemotherapy or radiation after surgical treatment? Yes No If yes, please explain _____

I signify that, to the best of my knowledge, the information provided is correct.

Signed: _____