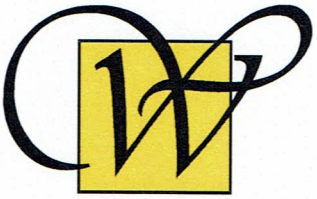

Deborah J. White, MD PC
Aesthetic & Reconstructive Surgery

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?

☐	Nipple discharge	☐	Breast lumps or breast cysts
☐	Breast trauma	☐	Breast infection (Mastitis)
☐	Inverted nipples	☐	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: _____