Breast Information Sheet

Patient Name: _____

Current Physical Concerns: (answer highlighted sections as applicable)

BREAST REDUCTION:

_____ Size & Weight of Breasts (611.1)

_____ Upper Back Pain / Discomfort (724.1)

_____ Lower Back Pain / Discomfort (724.2)

_____ Neck Pain / Ache (723.1)

_____ Shoulder Pain / Ache / Grooving (723.9)

_____ Breast Pain / Tenderness (611.71)

_____ Rashes Under / Between Breasts (695.89)

* Current Bra Size: _____ Desired Bra Size: _____

* Occupation: _____ Lifting in Job? _____

* Do you know anyone who has had a breast reduction? _____

BREAST AUGMENTATION:

_____ Lack of Fullness (whole breast – upper breast) _____ Lack of cleavage

What shape do you want? Full - cleavage - natural - slight droop

* Do you know anyone who has had breast augmentation? _____

Breast History:

* Have you ever had surgery or a biopsy on your breasts? No: ___ Yes: ___ (give details)

_____

* Has your mother, sisters or grandmother had a biopsy on their breast? No: ___ Yes: ___

_____

* Have you, your mother, sister, aunts or grandmothers had breast cancer? No: ___ Yes: ___

_____

* Have you ever had a mammogram? No: ___ Yes: ___ Normal / Abnormal Most recent date: _____

* Have you ever had therapy for any back / neck complaints? Where? _____

* Age of first menstrual period: _____ Age of first pregnancy: _____

Is there any other information about your general / medical health that we should be aware of? _____

_____

_____

_____ _____

Patient signature Date

Office Use:

Reduction – estimated volume to be removed for ____ cup: Right - _____gms Left - _____gms

Augmentation – estimated implant size _____. Volume discrepancy? _____. Asymmetries? _____