BREAST HISTORY

(Please note: some questions may be repeated)

Name:	Date:
What is the reason of your visit today?	
Is there a family history of this breast condition?	
What size bra do you currently wear?	_Size Preference:
What age did you begin to menstruate? Are y	our periods regular?
Do your breasts change during your menstrual cycle?	How?
How many times have you been pregnant?	ChildrenAges
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, n	nasses, or surgery?
LumpsDischargePain	Infections
If so, please explain:	
When was your last Mammogram?	
Do you do routine breast exams of yourself?	How often?

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Have you seen any other doctors regarding this procedure? 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: Please list any treatment pertaining to these symptoms including the provider:	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 seen any oth	er doctors regarding this	procedure?	
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: Please list any treatment pertaining to these symptoms including the provider:	Are you familiar with the surgical procedures that you are considering?			
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What would you consider to be your general health?	Have you had previous	cosmetic surgery?		
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Please list any treatment pertaining to these symptoms including the provider:	Neck pain	Rash under breast	Back pain	
Please list any treatment pertaining to these symptoms including the provider:	Shortness of breathLimitation of physical activities			
	If so, please explain:			
If a very the care of 40 have very had a manner within the leaf very 20 Very	Please list any treatme	nt pertaining to these sy	mptoms including the provider:	
If over the age of 40, have you had a mammogram within the last year? Yes No	If over the age of 40, by	ave vou had a mammod	ram within the last year? Ves	No

Thank you