

Robert J. Spies, MD, FACS
Aesthetic and Reconstructive Plastic Surgery

BREAST SURGERY HISTORY FORM
(Please complete all items. Please print.)

Name: _____ Date: _____

1. What is your particular breast problem? _____

2. Does this run in female members of your family? No Yes

3. What is your Height? _____ Weight? _____ lbs
What is the maximum you have ever weighed in the past? _____ lbs

4. What size bra do you wear? _____ Padded or unpadded? _____

5. How many children do you have? _____ What are their ages? _____

6. Did you breast feed? _____ Bottle feed? _____ Out of choice? _____

7. Did your breasts change size with pregnancy? No Yes
If so how much (in Bra size)? _____

8. Have you ever had any breast diseases or breast tumors? No Yes
If so, please explain. (Type, Date of Surgery, Doctor) _____

9. Has anyone in your family ever had any breast diseases or breast tumors?
 No Yes (If yes, please specify)

10. Have you had a mammogram (breast x-ray) in the past No Yes
If yes, please give the Date and Results of your last test: _____

11. Have you ever had a breast reduction, enlargement or lifting? No Yes
If yes, please explain (Type, Date of Surgery, Doctor) _____

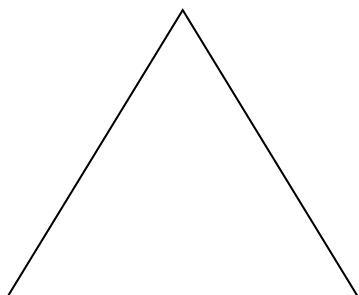
12. Have you had **any** of the following breast problems? (Please check the appropriate box)
 Nipple discharge Breast lumps (or breast cysts)
 Breast Trauma Breast infection (Mastitis)
 Inverted nipples Breast pain or swelling

13. Are you taking birth control pills (or receiving estrogen shots)? No Yes
If yes, please specify: _____

14. If you were treated for breast cancer, did you receive chemotherapy or radiation after surgical treatment? No Yes (If yes, please explain) _____

Signify that the information provided above is correct to the best of my knowledge.

Signed X _____



IM = _____
N/A → IM
RT. _____
LT. _____
VOLUME ____ > ____