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AZPLASTICSURGERYCENTER

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

Name: _____ Date: _____

1. What is your particular breast problem? _____

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

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

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

5. Did you breast feed? _____

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

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

8. Has anyone in your family ever had any breast diseases or breast tumors?

No Yes (If yes, please specify)

9. 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: _____

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

11. Have you had **any** of the following breast problems? (Please check the appropriate box)

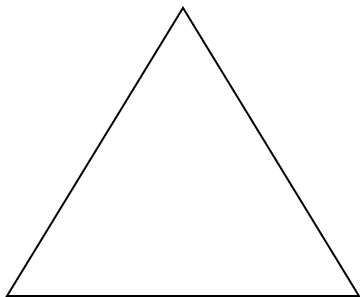
<input type="checkbox"/> Nipple discharge	<input type="checkbox"/> Breast lumps (or breast cysts)	<input type="checkbox"/> Shoulder pain
<input type="checkbox"/> Breast Trauma	<input type="checkbox"/> Breast infection (Mastitis)	<input type="checkbox"/> Back pain
<input type="checkbox"/> Inverted nipples	<input type="checkbox"/> Breast pain or swelling	<input type="checkbox"/> Neck pain

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

13. Are your Breasts presently at the largest size they have ever been?

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

Signed X _____



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