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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 Max you have weighed? _____________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 turmors? { } 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)____

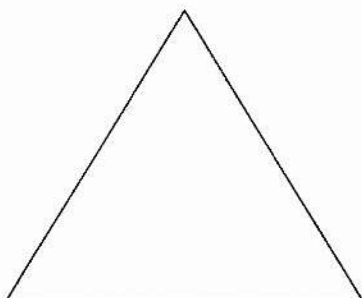
11. Have you had **any** of the following breast problems? (Please check the appropriate box)

{ } Nipple discharge
{ } Breast Trauma
{ } Inverted nipples
{ } Breast lumps (or breast cysts)
{ } Breast infection (Mastitis)
{ }Breast pain or swelling
{ } Shoulder pain
{ } Back pain
{ } 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?



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