

High Plains Plastic and Reconstructive Surgery

Breast Summary

Patient's Name _____ Age _____ Date _____

GENERAL:

- | | |
|--|--|
| 1. Do you smoke? _____ Package(s) per day _____ | 9. How large would you like to be? _____ |
| 2. Do you drink coffee? _____ cups per day _____ | 10. Are your breast equal in size? _____ |
| 3. Do you drink alcoholic beverages? _____ | 11. Do you have scoliosis/curvature of the spine? _____ |
| Ounces per day _____ | 12. Do your breasts sag? _____ |
| 4. Do you have diabetes? _____ | 13. Do you have fibrocystic disease? _____ |
| 1. How tall are you? _____ | 14. Have you ever had a lump in your breast? _____ |
| 2. What is your current weight? _____ | 15. Have you ever had a breast biopsy or breast surgery? _____ |
| 3. Are you pregnant? _____ | 16. Do you have a family history of breast cancer on |
| 4. Number of children you have? _____ | your mother's side? _____ |
| 5. Do you plan any more children in the near future? _____ | 1. What is you bra size? _____ |
| 6. Did you breast-feed your children? _____ | 2. Do you have neck/shoulder pain? _____ |
| 7. Did your breasts enlarge with your pregnancy? _____ | 3. Do you have back problems? _____ |
| 8. What bra size are you now? _____ | 4. Do you have skin irritation beneath your breasts? _____ |
| | 5. When was your last Mammagram? _____ |

1. What medications are you presently taking? Please include all over-the-counter medications, as well as the amounts you take per day: _____

2. List any medications you are allergic to: _____

3. Have you had any previous surgery including plastic/cosmetic surgery? _____
If so, list what kind of surgery, when you had it, and the doctor's name _____

4. Have you ever consulted a professional for emotional problems: _____

5. Please check yes or no if you have had or do have any of the following conditions:

- | | |
|---|--|
| Allergies or Hay Fever.....Y or N | Have a blood disease?.....Y or N |
| Chronic sinus problems.....Y or N | Heart problems.....Y or N |
| Chronic bronchitis.....Y or N | High blood pressure.....Y or N |
| Asthma.....Y or N | Low blood pressure.....Y or N |
| Chest problems.....Y or N | Kidney problems.....Y or N |
| Epilepsy or seizures.....Y or N | Liver problems.....Y or N |
| Thyroid disease.....Y or N | Do you have muscle weakness?.....Y or N |
| Blood clotting problems.....Y or N | Arthritis.....Y or N |
| Are you taking a blood thinner.....Y or N | Do you take steroids?.....Y or N |
| Bruise easily.....Y or N | Do you wear glasses/contact lens?.....Y or N |
| Anemic.....Y or N | Do you have false teeth or caps?.....Y or N |

6. Your reason for seeing the doctor today: _____