BREAST EVALUATION QUESTIONNAIRE

NAME_____ AGE_____ BRA SIZE_____ HT._____ WT._____

I AM INTERESTED IN:

□ BREAST ENLARGEMENT □ BREAST IMPLANT REMOVAL □ INVERTED NIPPLE REPAIR
□ BREAST LIFTING □ BREAST IMPLANT REVISION/EXCHANGE □ AREOLA/NIPPLE REDUCTION

HOW LONG HAVE YOU CONSIDERED THIS TYPE OF SURGERY?_____

HAVE ANY FRIENDS OR FAMILY HAD THIS TYPE OF SURGERY? □ YES □ NO WERE THEY SATISFIED? □ YES □ NO

WHO?_____

DID THEY EXPERIENCE ANY PROBLEMS? □ YES □ NO WHAT KIND?_____

DO YOU HAVE ANY OF THE FOLLOWING?

NIPPLE DISCHARGE?	□ YES □ NO	BREAST PAIN?	□ YES □ NO
BREAST MASSES?	□ YES □ NO	SKIN CHANGES OVER THE BREAST?	□ YES □ NO
FIBROCYSTIC?	□ YES □ NO	DIFFICULTY EXAMINING YOUR BREASTS?	□ YES □ NO

ARE YOU SELF-CONSCIOUS ABOUT YOUR BREASTS? □ YES □ NO
DO YOU HAVE DIFFICULTY BUYING PROPERLY-FITTING CLOTHING AS A RESULT OF YOUR BREASTS? □ YES □ NO
DO YOUR BREASTS CHANGE IN SIZE AROUND THE TIME OF YOUR PERIOD? □ YES □ NO
DO YOU PRACTICE MONTHLY BREAST SELF-EXAMINATIONS? □ YES □ NO

WHAT WAS THE DATE OF YOUR LAST MAMMOGRAM?_____

RESULTS:_____

HAVE YOU HAD ANY PREVIOUS BREAST SURGERY? □ YES □ NO
TYPE_____ DATE_____ RESULTS_____

ANY FAMILY HISTORY OF BREAST CANCER? □ YES □ NO
WHO?_____ AT WHAT APPROXIMATE AGE?_____

HOW MANY CHILDREN DO YOU HAVE?_____ DID YOU BREAST FEED THEM □ YES □ NO IF YES, HOW LONG?_____

DO YOU SMOKE CIGARETTES? □ YES □ NO HOW MANY?_____

DO YOU TAKE ASPIRIN OR ASPIRIN-CONTAINING PRODUCTS? □ YES □ NO

DO YOU TAKE STEROIDS? □ YES □ NO DO YOU HAVE ANY DIFFICULTY HEALING WOUNDS? □ YES □ NO

DO YOU HAVE DIABETES? □ YES □ NO DO YOU SCAR POORLY? □ YES □ NO

PLEASE COMPLETE THESE QUESTIONS IF YOU ALREADY HAVE BREAST IMPLANTS:

1. WHEN DID YOU FIRST HAVE YOUR BREAST IMPLANTS?_____

WHERE?_____ BY WHOM? _____WHAT TYPE OF IMPLANTS? _____

WHAT SIZE IMPLANTS? _____

WHERE WERE YOUR INCISIONS? □ UNDER THE BREAST □ AROUND THE NIPPLES □ IN THE ARMPIT

WHERE ARE THEY PLACED? □ ON TOP OF THE MUSCLE □ UNDER THE MUSCLE

2. WHAT SIZE BRA DID YOU WEAR BEFORE YOUR IMPLANTS?_____

_____
Patient Signature Date