BREAST EVALUATION QUESTIONNAIRE

Name ___________________________ Age _____ Bra Size_____ Ht._____ Wt._____

I am interested in: Breast enlargement □  Breast Lifting □  Breast implant removal □
Breast implant exchange □  Inverted nipple repair □  Areola/Nipple Reduction □

How long have you considered this type of surgery? ___________________________

Have any friends or family had this type of surgery? Yes No
Who? ___________________________ Were they satisfied? Yes No

Did they experience any problems? Yes No
What kind? ___________________________

Do you have any of the following?
Nipple discharge? ......................... Yes____ No____
Breast masses? ............................. Yes____ No____
Fibrocystic? ................................. Yes____ No____
Breast pain? ................................. Yes____ No____
Skin changes over the breasts? ........... 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 _________
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 diabetes? Yes No

Do you have any difficulty healing wounds? 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?  (Please circle)
       Under the breast  Around the nipples  In the armpit
   Where are they placed?  (Please circle)
       On top of the muscle  Under the muscle

2. What size bra did you wear before your implants? ____________________________