BREAST EVALUATION QUESTIONNAIRE

Name__________________________________________ Age_____
Bra Size_______ Ht.______ Wt._______

I am interested in:

Breast Reconstruction □  Breast enlargement □  Breast Lifting □
Breast implant removal □  Breast implant revision/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   If yes, how much____________________________
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 __________________________
2. Physician __________________________________________________________
   Office Address ________________________________________________________
   What type of implants? Silicone / Saline / Other___________________________
   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? ________________________