Breast Evaluation Questionnaire

Name:____ Age: ________

Bra Size:________________ Height: ______________ Weight:__________

Have you noticed if one breast is larger than the other?_______________________________

I am in interested in (circle):

Breast Reduction
Breast Lift
Breast Implant Revision/Exchange
Breast Augmentation
Breast Implant Removal

How long have you considered this type of surgery?__________________________________

Do you have friends or family who had this type of surgery?___________________________

Who?___________________________ Were they satisfied?__________________________

Did they experience any problems, and if so, what type of issues?____
____

Do you have any of the following (yes or no):

Nipple discharge	_______________________________________
Breast Masses (currently)	_______________________________________
History of breast masses	_______________________________________
Fibrocystic Condition of the Breasts	_______________________________________
Breast Pain	_______________________________________
Skin Changes Over the Breast	_______________________________________
Dimpling of the Skin of the Breast	_______________________________________

Are you self-conscious about your breasts:____

Do you do practice monthly self breast examinations:________________________________

Have you ever had a mammogram?____

If so, when was it, what was the reasoning for the exam, and what were the results?____
____

Is there a family history of breast cancer?____

If so, which relatives and how old were they at the time of diagnosis?____
____

Did you give birth to any children?____

If so, how many children and how old are they?____

Did you breast feed them? If yes, for how long?____
____

Do you have any difficulty healing wounds?____

Do you scar poorly?____

Do you have any liver disease? If so, what type:____

Do you drink alcohol? If so, how much?____

Do you have diabetes?____

Do you smoke cigarettes, and if so, how much?____

Do you have a history of depression, self-harm, suicide, or other psychiatric issues?____

When was your last menstrual period?____

Do you take Aspirin or any other blood thinner? If so, why?____

Do you or anyone in your family have a history of blood clots?____
____

Do you take steroids?____
____

Do you have an autoimmune or rheumatologic disease?____

Do you have fibromyalgia or complex regional pain syndrome?____

Are you currently under the care of a physician?____

Are you actively losing weight?____

What was your highest and lowest weight in the past 12 months?____

If you have previously had breast implants, please complete the following:

1. When were they placed?____
2. Surgeon and office:____
   ____
3. What type of implants (saline vs. silicone vs. other):_______________________________
4. Are they textured or smooth:____
5. Where are your incisions (i.e. under the breast, around the nipples, or in the armpit)?____
6. Where are the implants-above the muscle or below:____
7. What size bra were you before the implants:____________________________________
8. Did you have any issues or complications:____
   ____