

## AUGMENTATION / MASTOPEXY / REDUCTION HISTORY

Name \_\_\_\_\_ Date \_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_

Is there a family history of this breast condition? \_\_\_\_\_

What is your Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_

What size bra do you currently wear? \_\_\_\_\_ Size Preference \_\_\_\_\_

What age did you begin to menstruate? \_\_\_\_\_ Are your periods regular? \_\_\_\_\_

Do your breasts change during your menstrual cycle? \_\_\_\_\_ How? \_\_\_\_\_

How many times have you been pregnant? \_\_\_\_\_ Children \_\_\_\_\_ Ages \_\_\_\_\_

Did your breasts change with pregnancy? \_\_\_\_\_ How? \_\_\_\_\_

Did you breast feed your children? \_\_\_\_\_ How long? \_\_\_\_\_

Do you anticipate future pregnancies? \_\_\_\_\_

If so, do you plan on breast feeding? \_\_\_\_\_

Has anyone in your family had breast disease? \_\_\_\_\_

If so, please explain \_\_\_\_\_

Do you have any personal history of breast disease, masses, or surgery? \_\_\_\_\_

Lumps \_\_\_\_\_ Discharge \_\_\_\_\_ Pain \_\_\_\_\_ Infections \_\_\_\_\_

If so, please explain \_\_\_\_\_

When was your last Mammogram? \_\_\_\_\_

Do you do routine breast exams of yourself? \_\_\_\_\_ How often? \_\_\_\_\_

What medications are you currently taking?

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Fred Wilder, M.D.

Why are you thinking about having this surgery? \_\_\_\_\_

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Are you familiar with the surgical procedure you are considering? \_\_\_\_\_

Do you know people who have had this surgery? \_\_\_\_\_

Have you had previous cosmetic surgery? \_\_\_\_\_

If so, what and when? \_\_\_\_\_

\_\_\_\_\_

What would you consider to be your general health? \_\_\_\_\_

Is there anything you feel like we need to know considering your medical history? \_\_\_\_\_

\_\_\_\_\_

## **BREAST REDUCTION PATIENTS ONLY**

Please indicate which of the following symptoms you have experienced:

Shoulder pain \_\_\_\_\_ Breast pain \_\_\_\_\_ Shoulder grooving \_\_\_\_\_

Neck pain \_\_\_\_\_ Rash under breasts \_\_\_\_\_ Back pain \_\_\_\_\_

Shortness of breath \_\_\_\_\_ Limitation of physical activities \_\_\_\_\_ If so, please

explain \_\_\_\_\_

\_\_\_\_\_

Other symptoms \_\_\_\_\_

\_\_\_\_\_

Have you seen any other doctors for treatment of any of these symptoms? \_\_\_\_\_

Who and When \_\_\_\_\_