

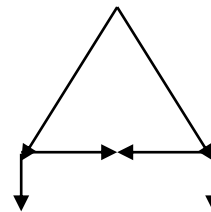

Premier Plastic Surgery Center
Breast Questionnaire

NAME _____ DATE _____/_____/201_____
 Number of pregnancies _____ Number of deliveries _____
 Did you nurse? _____ If so, how many months with each? _____
 What was the maximum bra cup size you attained? _____
 Current bra size _____ Is it padded? Yes No
 Do you feel your breasts are the same size and shape? _____ If no, which is larger? Right Left
 If you have **large breasts**, are you experiencing ___neck pain? ___back pain? ___bra strap pain? ___numbness or tingling of the arms? ___rashes under your breasts? ___"heavy" feeling to your breasts? ___breast pain? ___other? _____
 Have you ever had breast surgery? _____ If so, please explain _____

 Ever have scoliosis? _____ Was it ever treated? _____
 Have you ever taken Accutane? _____ When? _____ How long? _____
 Do you take birth control pills or female hormone replacement? Yes No. If "yes", are you aware that you have increased risks of blood clots? Yes No
 Any blood relatives with breast cancer? ___ If so, relation _____
 Who examines your breasts regularly? ___self ___Gynecologist ___other physician
 Do you have breast pain? _____ Does your menstrual cycle affect your breasts? _____
 How would you rate your nipple sensation on the right? Normal Excessive Less than normal
 How would you rate your nipple sensation on the left? Normal Excessive Less than normal
 Most recent mammogram (x-rays)? _____ Results _____
 Please circle any of the following exercises you like to do: Bench press Yoga Pilates
 Push-ups Chest Flyes Cross Fit Other chest exercises _____
 What is your height? _____ Weight? _____
 Do you want to be: ___Enlarged ___Enlarged and lifted ___Lifted only ___Reduced ___Have implants exchanged ___Breast reconstruction after mastectomy ___Other _____
 Medicine is an art, not an exact science, so nothing exact can be promised. But, given the choice, approximately what size breasts would you ideally like to have? _____

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Exam Date _____/_____/201_____
 Excavatum ___ Carinitus ___ Scoliosis ___ Asymmetry (R < > L)
 Constriction: R ___ L ___
 Tubular: R ___ L ___ Upper breast pinch _____ cm
 Striae: R ___ L ___
 Breast scars: R ___ L ___ Location _____
 Masses R ___ L ___ None _____
 Adenopathy R ___ L ___ None _____



Skin envelope: tight ___ moderate ___ loose ___ Psuedoptosis ___ Ptoisis ___
 Width R _____ L _____ Cleavage _____
 Capsular contractures R _____ L _____ Implants Displaced R _____ L _____
 Implants: Submuscular ___ Subglandular ___ Rippling _____ Animation _____

PLAN: Ax Areola IMC Full pexy Mod pexy Capsulectomy (R L) Capsulorrhaphy (R L)
 Exchange Submusc. Subgland. Change Pocket Saline Tx Smooth Silicone Anatomic
 Reduction _____ gms on R _____ gms on L (___Ax lipo)
 Pre-Op mammogram Y N
 Dangers of smoking reviewed Y N
 Dangers of BCP's or HRT reviewed Y N
 Options/risks/uncertainties reviewed Y N