

Aesthetic Consultants of Iowa

**** BREAST INFORMATION RECORD ****

Please complete this for your record

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Age: _____ Height: _____ Weight: _____ Bra size: _____

Last Menstrual Period _____ Age of first period: _____

Family history of breast cancer?

Mother: Yes No

Maternal grandmother: Yes No

Sisters: Yes No

Number of Pregnancies _____ Ages of children: _____

Did you breast feed these children? Yes No

Have you had a mammogram? Yes No

What Years? _____

Methods of birth control ? _____

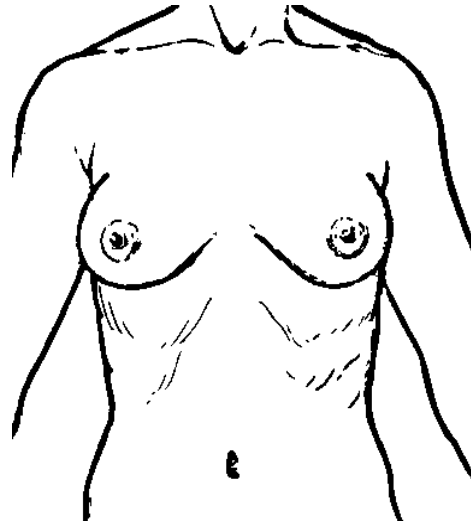
Do you do monthly breast self-examinations? Yes No

Any changes that concern you? Yes No _____

Previous breast surgery? Yes No _____

Why are you considering surgery at this time? _____

What are your expectations and desires from surgery? _____



Date _____

(Signature)

COMPLETE BACK OF FORM FOR BREAST REDUCTION ONLY

FOR PHYSICIAN USE ONLY

Size: R = L R < L R > L

Skin: Tight Straie

Inframammary crease: R = L

R > L

R < L

GRAMS TO BE REMOVED: RIGHT SIDE _____ LEFT SIDE _____

- | | | | |
|---------------------------------|---|---------------------------------|---|
| <input type="checkbox"/> 611.1 | MEDICARE DIAGNOSES | <input type="checkbox"/> 719.41 | Pain in shoulder region |
| <input type="checkbox"/> 354.2 | Hypertrophy of breast (severe) | <input type="checkbox"/> 781.9 | Poor posture |
| <input type="checkbox"/> 611.71 | Paresthesia of ulnar nerve | <input type="checkbox"/> 909.2 | Late effect radiation therapy |
| <input type="checkbox"/> 695.89 | Pain in breasts | <input type="checkbox"/> 909.3 | Late effect surgical complication |
| <input type="checkbox"/> 705.83 | Intertrigo | <input type="checkbox"/> 996.79 | Periprosthetic capsular fibrosis |
| <input type="checkbox"/> 706.1 | Hidrandenitis Suppurative | <input type="checkbox"/> 998.3 | Postoperatic wound disruption |
| <input type="checkbox"/> 723.1 | Acne | <input type="checkbox"/> 998.5 | Postoperative wound infection |
| <input type="checkbox"/> 723.9 | Pain in neck | <input type="checkbox"/> 611.9 | Unspecified breast disorder |
| | Unspecified musculokeletal disorder & symptoms. Referable to neck (shoulder pain) | <input type="checkbox"/> 996.54 | Complication, mechanical of breast prosthesis |
| <input type="checkbox"/> 724.1 | Pain in thoracic spine | <input type="checkbox"/> V10.3 | Personal hx of breast carcinoma |
| <input type="checkbox"/> 724.2 | Low back pain | <input type="checkbox"/> V16.3 | Family hx of breast carcinoma |
| <input type="checkbox"/> | OTHER DIAGNOSES | <input type="checkbox"/> | |
| <input type="checkbox"/> 782.2 | Shoulder grooving | <input type="checkbox"/> | |
| <input type="checkbox"/> | | <input type="checkbox"/> | |

Breast Reduction

Patient Name: _____ Date of Birth: _____

____ Back Pain – Duration _____ (years/months/days)

Treatment _____

By Whom: _____

Treatment Dates: _____

____ Shoulder Pain – Duration _____ (years/months/days)

Treatment _____

By Whom _____

Treatment Dates: _____

____ Neck Pain – Duration _____ (Years/months/days)

Treatment _____

By Whom _____

Treatment Dates: _____

____ Rashes underneath/between breasts – Duration _____ (years/months/days)

Treatment _____

By Whom _____

Treatment Dates: _____

____ Any additional problems? _____ Duration _____

Treatment _____

By Whom _____

Treatment Dates: _____

Signature _____ Date _____