

Gynecomastia Information Record

please complete this for your record

Name _____ DOB: _____ Date _____

Height: _____ Weight: _____

Areas of concern: _____

What changes in this area concern you: _____

At what age first noticed: _____ Have you ever or are you currently taking steroids? _____

Do you have any pain in this area? _____ Please circle area affected: Both sides/right side/left side.

Have you been treated in the past for any psychological pain this condition may have caused? _____

If so, by whom? _____

Is there any history of male breast cancer in your family? _____. If so, what relation _____

