

Name _____ DOB: _____ Date _____

Height: _____ Weight: _____ Months at current weight? _____ Bra size: _____

Why are you considering surgery now?: _____

What are your expectations/desires from surgery?: _____

Activity Level: _____ Planning any weight loss?: Yes / No

BREAST HISTORY

Last menstrual period: _____

Age at first period: _____

Number of children: _____

Ages of children: _____

Did you breast feed your children? Yes / No

Plan on having more children? Yes / No

Method of current birth control? _____

Date of last mammogram: _____

Findings on last mammogram: _____

Any previous breast surgery or biopsies (dates/findings)?

**Any history of breast cancer in your family?
If yes, please list approximate age of onset.**

Yes No

- Mother
- Maternal grandmother
- Maternal aunt
- Daughter
- Paternal grandmother
- Paternal aunt
- Any male member of your family
- BRCA positive family member

Do you do monthly breast self-examinations? Yes / No
Any breast changes that concern you? Yes / No

Patient Signature: _____

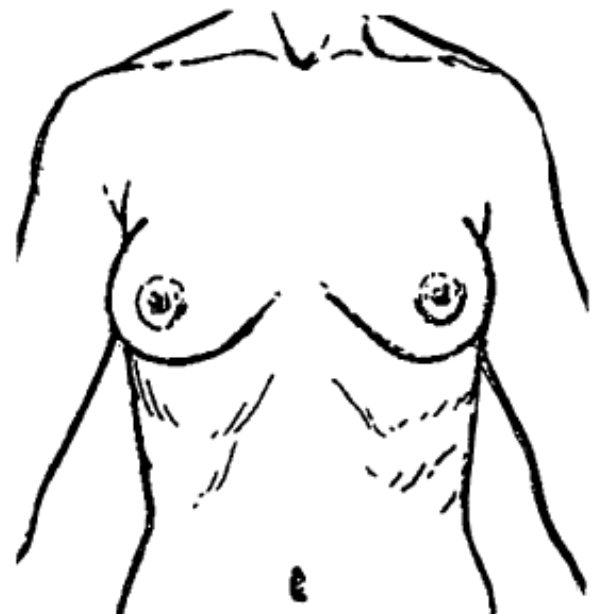
FOR PHYSICIAN USE ONLY

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 _____

ICD9	ICD 10	
611.1	N62	breast hypertrophy
782.1	R21	rash & other nonspecific skin eruption
695.89	L30.4	intertrigo
724.1	M54.6	pain in thoracic spine
724.5	M54.9	back pain, unspecified
723.1	M54.2	pain in neck
719.41	M25.519	pain in shoulder region
782.2	R22.9	shoulder grooving

PLAN:



Provider Reviewed _____

Breast Reduction

Patient Name: _____ Date of Birth: _____

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

Treatment _____

By Whom: _____

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

Treatment _____

By Whom _____

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

Treatment _____

By Whom _____

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

Treatment _____

By Whom _____

____ Shoulder grooving? Duration __ (years/months/days)

Treatment _____

By Whom _____

Activities of Daily Living you are unable to do because of breast size _____

Additional problems/info _____

Provider Reviewed _____