UNIVERSITY OF IOWA HEALTH CARE | Aesthetic Consultants of Iowa PLASTIC AND RECONSTRUCTIVE SURGERY

Breast Form

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)?

_____

_____

Do you do monthly breast self-examinations? Yes / No

Any breast changes that concern you? Yes / No

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

Yes	No	
☐	☐	Mother
☐	☐	Maternal grandmother
☐	☐	Maternal aunt
☐	☐	Sister
☐	☐	Daughter
☐	☐	Paternal grandmother
☐	☐	Paternal aunt
☐	☐	Any male member of your family
☐	☐	BRCA positive family member

Patient Signature:

_____

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FOR PHYSICIAN USE ONLY

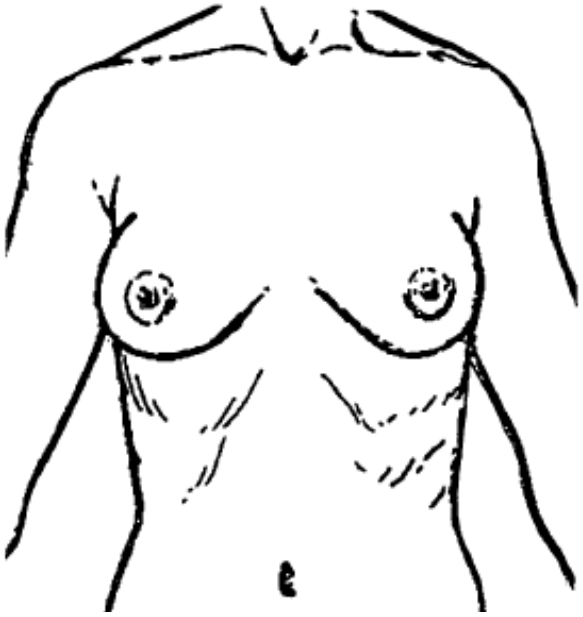
Size: R=L R < L R > L Skin: Tight Straie

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 _____