

Name _____ DOB: _____ Date _____

Height: _____ Weight: _____ Months at current weight? _____ Activity Level: _____

Areas of concern: _____

What changes in this area concern you: _____

At what age first noticed: _____

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

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

Do you have a personal history of the following:

- | | | |
|--------------------------|--------------------------|-----------------------------------|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain / Masses of Testicles |
| <input type="checkbox"/> | <input type="checkbox"/> | Previous breast surgeries |
| <input type="checkbox"/> | <input type="checkbox"/> | Testicular tumor |
| <input type="checkbox"/> | <input type="checkbox"/> | Adrenal tumor |
| <input type="checkbox"/> | <input type="checkbox"/> | Personal use of anabolic steroids |
| <input type="checkbox"/> | <input type="checkbox"/> | Personal use of estrogen |
| <input type="checkbox"/> | <input type="checkbox"/> | Personal use of growth hormone |
| <input type="checkbox"/> | <input type="checkbox"/> | Personal use of marijuana |
| <input type="checkbox"/> | <input type="checkbox"/> | History of obesity |
| <input type="checkbox"/> | <input type="checkbox"/> | Hyperthyroidism |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver disease or cirrhosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic kidney disease |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV |
| <input type="checkbox"/> | <input type="checkbox"/> | Klinefelter's syndrome |

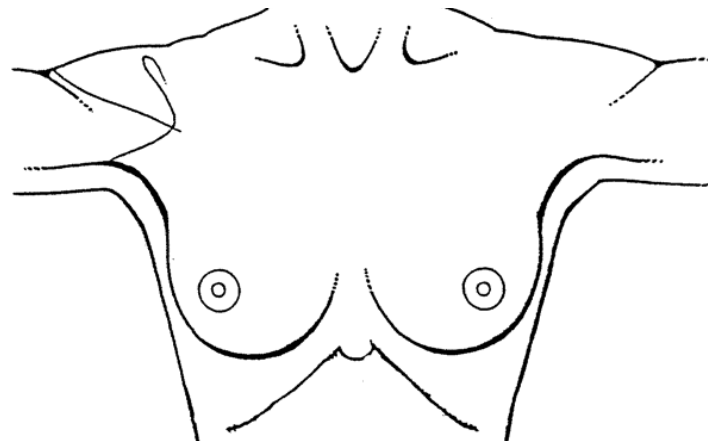
Have you ever used the following medications:

- | | | |
|--------------------------|--------------------------|---------------------------|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Finasteride |
| <input type="checkbox"/> | <input type="checkbox"/> | Spirolactone |
| <input type="checkbox"/> | <input type="checkbox"/> | Ketoconazole |
| <input type="checkbox"/> | <input type="checkbox"/> | Metronidazole |
| <input type="checkbox"/> | <input type="checkbox"/> | Isoniazid |
| <input type="checkbox"/> | <input type="checkbox"/> | Ranitidine |
| <input type="checkbox"/> | <input type="checkbox"/> | Methotrexate |
| <input type="checkbox"/> | <input type="checkbox"/> | Digoxin |
| <input type="checkbox"/> | <input type="checkbox"/> | Verapamil |
| <input type="checkbox"/> | <input type="checkbox"/> | Diltiazem |
| <input type="checkbox"/> | <input type="checkbox"/> | Amiodarone |
| <input type="checkbox"/> | <input type="checkbox"/> | Enalapril |
| <input type="checkbox"/> | <input type="checkbox"/> | Diazepam |
| <input type="checkbox"/> | <input type="checkbox"/> | Antipsychotic medications |
| <input type="checkbox"/> | <input type="checkbox"/> | Metoclopramide |
| <input type="checkbox"/> | <input type="checkbox"/> | Phenytoin |
| <input type="checkbox"/> | <input type="checkbox"/> | Statins |

FOR PHYSICIAN USE ONLY

Size: R=L R < L R > L **Skin:** Tight Straie
Inframammary crease: R=L R>L R<L

- Grade I:** Small breast enlargement, localized button of tissue around the areola.
- Grade II:** Moderate breast enlargement exceeding areola boundaries with edges that are indistinct from the chest.
- Grade III:** Moderate breast enlargement exceeding areolar boundaries with edges that are distinct from the chest with skin redundancy.
- Grade IV:** Marked breast enlargement with skin redundancy and feminization of the breast.



Provider Reviewed _____