ROBERT J. SPIES, MD, FACS
Aesthetic Plastic Surgery

BREAST HISTORY SURGERY QUESTIONNAIRE

Name:_____Date:_____

1.What is your particular breast problem?_____

_____

2.What is your Height?_____ Weight?_____lbs Max you have weighed? _____lbs

3. What size bra do you wear?_____ Padded or unpadded?_____

4. How many children do you have?_____ What are their ages?_____

5. Did you breast feed?_____

6. Did your breasts change size with pregnancy? { } No { }Yes
If so how much (in Bra size)?_____

7. Have you ever had any breast diseases or breast turmors? { } No { }Yes
If so, please explain. (Type, Date of Surgery, Doctor)_____

8. Has anyone in your family ever had any breast diseases or breast tumors?

{ } No { }Yes (If yes, please specify)
_____

9. Have you had a mammogram (breast x-ray) in the past { } No { } Yes
If yes, please give the Date and Results of your last test:_____

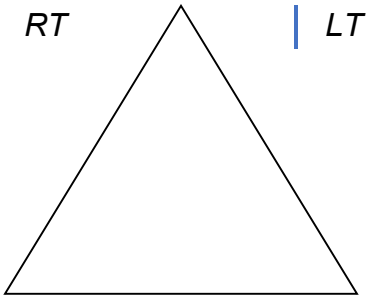
10. Have you ever had a breast reduction, enlargement or lift? { } No { } Yes
If yes, please explain (Type, Date of Surgery, Doctor)_____

11. Have you had **any** of the following breast problems? (Please check the appropriate box)
{ } Nipple discharge { } Breast lumps (or breast cysts) { } Shoulder pain
{ } Breast infection (Mastitis) { } Back pain
{ } Inverted nipples { }Breast pain or swelling { } Neck pain

12. Are you taking birth control pills (or receiving estrogen shots)? { } No { } Yes

If yes, please specify:_____

RT *LT*



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