PISARSKI MD
GULF COAST PLASTIC SURGERY

Breast History

NAME: ______________________________________ **AGE:** _______ **DATE:** __________________

The following information will help the doctor assess your individual needs. However, if you find any questions too personal or embarrassing, please don't hesitate to leave them unanswered and discuss it privately with the doctor.

REASON FOR CONSULTATION: (please check)

____AUGMENTATION
____BREAST MASS
____REDUCTION
____UPLIFT
____RECONSTRUCTION
____GENERAL EXAM
____OTHER ________________________
____

Have you had any previous breast surgery: ____YES ____NO

Type: ____

Date: ____

Do you have or have been told you have any of the following:

Breast lumps: ____Yes ____No
Breast pain: ____Yes ____No If YES, how much coffee/cola do you drink a day? ________
Fibrocystic disease: ____Yes ____No

Previous Mammogram

Date: _______________________________________

Where: _____________________________________

Results (if known):____

____

Family history of breast cancer: ____Yes ____No

____Mother
____Maternal Aunt
____Maternal Grandmother
____Sister
____Other _______________

Age at first menstrual period: ___________________
Age at last menstrual period: ___________________
Age at birth of first child: ___________________

Have you had prior consultation for this problem? ____Yes ____No

If so, with whom: ___________________________________

Breast Reduction and Augmentation Patients Only (OPTIONAL)

Bra size now:__________________________________

Bra size you think you would like: _______________