

Name: _____

Date: _____

1. What is your particular breast problem? _____

2. Does this run in female members of your family? _____
If so, who? _____
3. What is your height? _____ Weight? _____
4. What size bra do you wear? _____ Padded or unpadded? _____
5. How many children do you have? _____ What are their ages? _____

6. Did you breast feed? _____ Bottle feed? _____ Out of choice? _____
7. Did your breasts change size with pregnancy? _____ If so, how much in bra size
did it change? _____
8. Have you ever had any breast diseases or breast tumors? _____ If so, please explain
(type, date of surgery, doctor) _____
9. Has anyone in your family ever had any breast diseases or breast tumors? _____ If so,
please specify _____
10. How is your general health? _____
11. Have you ever had any serious illnesses? _____ If so, please specify _____

12. Are you allergic to any medicines? _____ If so, please specify _____

13. Do you have any bleeding tendencies? _____
14. Are you taking any medicines or birth control pills? _____
If so, please specify _____
15. Have you ever had a mammogram? _____ If so, when and where? _____

16. Have you ever had breast surgery? _____ If so, when and where? _____
