

## PATIENT BREAST INFORMATION

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Birthdate:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

**Do you smoke:** YES ( ) NO ( ) **How many packs per day:** \_\_\_\_\_

**If you do smoke, have you tried to quit:** YES ( ) NO ( ) Please explain: \_\_\_\_\_

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### Reason for Visit:

Breast Symptoms: (if applicable)

Unsatisfactory Appearance \_\_\_\_\_ Breast Pain \_\_\_\_\_ Nipple Discharge \_\_\_\_\_

Implant Problems \_\_\_\_\_ Upper Back Pain \_\_\_\_\_ Rashes \_\_\_\_\_

Neck Pain \_\_\_\_\_ Lower Back Pain \_\_\_\_\_ Infections \_\_\_\_\_

Absence of Breast/Nipple \_\_\_\_\_ Shoulder Pain \_\_\_\_\_

Breast Mass/Lump \_\_\_\_\_

### Breast Surgery History:

Procedures:	Date	Location	MD
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### Breast Cancer Treatment:

Radiation Therapy: Yes ( ) No ( ) Date Completed \_\_\_\_\_

Chemotherapy YES ( ) NO ( ) Date Completed \_\_\_\_\_

Other: \_\_\_\_\_

### Mammograms:

Date	Location	Findings
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### Family History Breast Conditions:

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**Breast Implant:** Do you currently have implants? Yes \_\_\_\_\_ No \_\_\_\_\_

Type: Saline \_\_\_\_\_ Silicone Gel \_\_\_\_\_ Size in CC's: \_\_\_\_\_

Position: Under muscle \_\_\_\_\_ Over muscle \_\_\_\_\_

Manufacturer: \_\_\_\_\_

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**Patient Signature**

**Date**