

BREAST AUGMENTATION/LIFT QUESTIONNAIRE

Patient Name: _____ Age: _____ Date: _____

Breast Size: _____ Desired Size: _____ Is size affected by weight gain/loss? YES/NO

In your opinion, do you desire to enlarge your breasts or eliminate drooping? _____

Children: YES/NO #: _____ Effects on breasts: _____

Smoker: YES/NO If yes, how much? _____ Have you had a mammogram? YES/NO

Where? _____ When? _____

Previous Breast Disease/Surgery: _____

Family History of Breast Cancer: _____

Medications: _____

For office use only

Exam:

SN-N Left: _____ Right: _____

IMC-N Left: _____ Right: _____

SYMMETRY:

STRIA:

PTOSIS:

MASSES/TENDERNESS:

PREVIOUS SCARS:

LATERAL FULLNESS:

DIAGRAMS:

ANY RISKS MORE LIKELY OR SPECIFIC IN THIS PATIENT? _____

PLAN:

SUBPECTORAL/SUBGLANDULAR

PERI-AEROLAR/INFRA-MAMMARY/TRANS-AXILLARY

IMPLANT SIZE: _____ TYPE: _____