

Anne M. Nickodem, M.D., F.A.C.S.

Aesthetic, Breast and Reconstructive Surgery

Breast History

Age at onset of menstrual cycle: _____ Is your cycle regular? _____

Current bra size: _____ For how long? _____

#Of pregnancies: _____ Your age at time: _____

Did you breast feed? _____ Duration: _____

Are you currently or at any time have you taken hormone supplements or therapy? _____

If yes, please list: _____

Have you ever had a mammogram: _____ Date of last study: _____ Where? _____

Findings: _____

Have you ever had any breast disease? _____ Type: _____

Have you ever had a breast biopsy? _____ Results: _____

Do you perceive your breasts to be symmetric in volume? _____ in shape: _____

If no, please describe differences: _____

History of breast cancer: Family: _____ Personal: _____

Do you experience any of the following symptoms?

- | | |
|------------------------------|-------------------------------|
| _____ neck | _____ nipple discharge |
| _____ back pain | _____ nipple inversion |
| _____ shoulder strain | _____ breast pain |
| _____ bra strap groove marks | _____ rashes under the breast |

Have you practiced conservative treatment such as?

- _____ Medications for back/breast/shoulder pain
List medications used: _____
Frequency medications needed: _____
Duration of medication used: _____
_____ Use of "sports" bra or "support" bra
Duration of use: _____
_____ Other (describe): _____
_____ None of the above

If you have had any of the following surgeries on your breasts, please indicate side and date:

- | | |
|------------------------|----------------------|
| Biopsy _____ | Augmentation _____ |
| Breast Lift _____ | Mastectomy _____ |
| Breast Reduction _____ | Reconstruction _____ |