BREAST SHEET

NAME:________________________________ DATE:____________________

1. WHAT IS YOUR PARTICULAR BREAST PROBLEM?

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2. DOES THIS RUN IN FEMALE MEMBERS OF YOUR FAMILY?____________ IF YES, WHOM?____

3. WHAT BRA SIZE DO YOU WEAR?__________________________________

4. HOW MANY CHILDREN DO YOU HAVE?______________________AGE(S)______

5. DID YOU BREAST FEED?________BOTTLEFEED?________ OUT OF CHOICE?__________

6. DID YOUR BREAST SIZE CHANGE WITH PREGNANCY?________ TO WHAT SIZE?____

7. HAVE YOU EVER HAD ANY BREAST DISEASES OR BREAST TUMORS?_______NO ________ YES. IF YES, PLEASE EXPLAIN:__________________________

8. HAS ANYONE IN YOUR FAMILY EVER HAD ANY BREAST DISEASE OR TUMORS? _________YES________NO

IF YES, PLEASE EXPLAIN: ____

9. HOW IS YOUR GENERAL HEALTH?________________________________

10. PLEASE DESCRIBE HOW YOU WOULD LIKE YOUR BREASTS TO LOOK:

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PLEASE USE DIAGRAM TO DEMONSTRATE ANY PROBLEM AREAS: