Breast Consultation History Form

For

Michael M. Papalian, MD

Reason for your consultation ____

Referring Physician or Other ____

Primary Care Physician ____

Would you like Dr Papalian to inform your Physician of your Consultation? Yes or NO

Age __________ Height _________ Current Weight __________

Bra Size Current Size _________ Largest Previous Size __________

Last Mammogram Date (If Any) ______________________

Where was your Mammogram performed _____________________________________

Do you Smoke ? ____ Do you take Blood Thinners ? ______ Do You have Diabetes ?______

Do You Have a Family History of Breast Cancer ? ________________

If You Have a Family History List Relationship and Age at Diagnosis

List____

Do You Have Children ________ Ages (If Applicable) __________________________

If you Have Children, Did You Breast Feed ? _________ For How Long ? ________________

Date of Last Breast Feeding ______________________

For Breast Reconstruction Consultations

Have you had a breast biopsy in the past yes_______ No _______

Biopsy Result ____

Performed Where ______________________ By Whom ____________________________

Have you Had any prior breast Surgery (List) __________________________________

For Breast Reduction Consultations

Do you have Neck/ Back or Shoulder Pain? Yes or No
Do you experience rashes under your Breasts? Yes or No
Does your Breast size limit your activities? Yes or No
Have you tried Anti-inflammatory Medication? Yes or No
Have You tried proper Bras for relief? Yes or No

Print Name ______________________ Signed _________________________Date________