



## MEDICAL HISTORY

Name: \_\_\_\_\_

Medical History (i.e. diabetes, high blood pressure, kidney problems, etc):

---

---

---

Surgical History (i.e. gallbladder, hysterectomy, breast biopsy, etc):

---

---

Family History (breast cancer, etc): \_\_\_\_\_

Social History:

Smoker:        Yes / No  
Alcohol use:  never / little / heavy  
Drug use:      never / occasional

How many children: \_\_\_\_\_

### Only fill out if you are coming in for breast augmentation and/or breast lift:

Bra size:

Before children \_\_\_\_\_  
During breastfeeding \_\_\_\_\_  
After breastfeeding/now \_\_\_\_\_  
Desired cup size \_\_\_\_\_

Do you think you need a lift?    Yes / No

Have you had a mammogram?    Yes / No        If yes, when? \_\_\_\_\_

Have you had any breast disease or lumps?    Yes / No

If yes, when and how were you treated? \_\_\_\_\_