KAROL A. GUTOWSKI, MD, FACS

AESTHETIC & RECONSTRUCTIVE SURGERY
CERTIFIED BY THE AMERICAN BOARD OF PLASTIC SURGERY
MEMBER AMERICAN SOCIETY OF PLASTIC SURGEONS

Confidential Health Questionnaire for Breast Lift & Reduction

Name _____ Today's Date _____

Age _____ Date of Birth _____ Email _____

Address _____ City_____ ZIP _____

Phone Number _____

Emergency Contact _____ Phone Number _____

Primary Care Physician _____ Phone Number _____

Reason for visit: _____

Current bra size _____ Desired bra size _____

Have you had a mammogram? No Yes Date and result _____

Have you had a physician examine your breasts? No Yes, Date and result _____

Do you perform a regular breast self exam? No Yes Any abnormalities? _____

Have you had any problems with your breast? No Yes Details _____

Has anyone in your family had breast problems? No Yes Details _____

Which of the following problems do you have that may be related to you breasts?

□ Back pain □ Neck pain □ Shoulder pain □ Breast pain □ Rashes under breasts

□ Poor posture □ Headaches □ Numb hands □ Grooves in shoulders from bra

What have you tried to make these problems better?

□ Medications □ Physical therapy □ Weight loss □ Special bras □ Chiropractic treatment

In what way does your breast size interfere with normal activities? _____

MEDICAL INFORMATION

Allergies □ None

□ Medications _____ Reaction _____

□ Environmental _____ Reaction _____

□ Latex Reaction _____

Medications (including dietary supplements, nonprescription and herbal products)

Past Medical History (list any past or current medical problems)

□ Cold sores or herpes infections

Past Surgical History (list any past procedures & operations, including complications)

□ Implant, pacemaker, defibrillator, or implantable medical device

Social History

Current Occupation _____

Do you smoke or use tobacco? No Yes

Packs per day _____

Year started _____ Year stopped _____

Do you drink alcohol? No Yes

Drinks per week _____

Do you use recreational drugs? No Yes

Marital Status: Married Single Widowed

Number of children _____

Will any dependents rely on you after surgery? _____

Are you planning on having more children? _____

Who will care for you after surgery? _____

Loss of pregnancies or spontaneous abortions _____

Family Medical History (please explain if any of these conditions have affected a blood relative)

□ Cancer □ Breast Disease □ Heart disease (heart attacks, heart bypass surgery) □ Abnormal reaction to anesthesia

Bleeding or Blood Clotting Disorders

Have you or any blood relative had problems with:

□ Abnormal or excessive bleeding

□ Abnormal or excessive blood clotting, also called Deep Venous Thrombosis (DVT) or Pulmonary Emboli (PE)

Do you have now, or have you been diagnosed as having (if yes, please explain)

□ Stroke
□ Thyroid disease
□ Anemia
□ Arthritis
□ Cancer or tumor
□ Diabetes mellitus
□ Heart attack
□ Heart failure
□ Kidney disease
□ Easy bruising
□ Asthma
□ Varicose veins
□ Seizures
□ Palpitations
□ Hepatitis
□ Stomach or duodenal ulcer
□ Stomach or intestinal bleeding
□ Irregular or rapid heart beat
□ High blood pressure
□ Frequent gum or nose bleeds
□ Angina or chest pain
□ Jaundice or liver disease
□ Mood disturbance
□ Heart murmurs
□ Shortness of breath or wheezing
□ Frequent heartburn or reflux
□ Fainting or dizziness
□ Nervous breakdown
□ AIDS or HIV positive
□ Immune disorders

Height _____ **Weight** _____ **lbs**

How did you hear about our practice?

□ Internet search □ Doctor □ Friend □ Other _____
□ Television □ Magazine □ Web site _____

Who can we thank for this referral? _____

Completed by _____ **Signature** _____

Section below to be completed by physician

Physical Exam: Height _____ Weight _____ lbs

Right Left

Masses

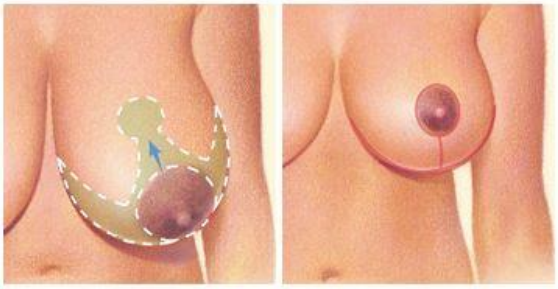
Notch - Nipple

Discharge

Nipple - IMF

Skin tone

R L



Impression:

Estimated amount to be removed: _____g per breast

Recommendations:

Signature _____ **Date** _____