THE LA JOLLA INSTITUTE
OF PLASTIC SURGERY

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BREAST SURGERY QUESTIONNAIRE

Please complete this form in order to assist Dr. Pietraszek in discussing your surgical needs and goals.

NAME: _____ **DATE:**_____

1. WHAT IS YOUR PARTICULAR BREAST CONCERN? _____

2. DOES THIS RUN IN FEMALE MEMBERS IN YOUR FAMILY? YES ( ) NO ( )

IF SO, WHO?_____

3. WHAT IS YOUR HEIGHT? ____ft. _____ in.

4. WHAT BRA SIZE DO YOU WEAR?_____ PADDED( ) UNPADDED( )

5. HOW MANY CHILDREN DO YOU HAVE?_____WHAT ARE THEIR AGES?

6. DID YOU BREAST FEED? YES ( ) NO ( )
BOTTLE FEED? YES ( ) NO ( )
DID YOU BOTTLE FEED OUT OF CHOICE? YES ( ) NO ( )

7. DID YOUR BREASTS CHANGE IN SIZE WITH PREGNANCY? YES ( ) NO ( )
IF SO, HOW MUCH (IN BRA SIZE)?

8. HAVE YOU EVER HAD ANY BREAST DISEASES OR
BREAST TUMORS? YES ( ) NO ( )
IF **YES**, PLEASE SPECIFY:_____

9. DO YOU HAVE ANY BLEEDING DISORDERS? YES ( ) NO ( )

10. IS THERE ANY FAMILY HISTORY OF BREAST CANCER ? YES ( ) NO ( )

11. IS THERE ANY HISTORY OF AUTO-IMMUNE DISEASES
(SUCH AS SCLERODERMA OR RHEUMATOID ARTHRITIS)
IN YOU OR YOUR FAMILY? YES ( ) NO ( )