**Name _____ Today's Date _____ Height _____ Weight _____**

**What brings you in today? _____** Age:

PAST AND CURRENT MEDICAL PROBLEMS

| History Of | Yes/No | Specify |
|---|---|---|
| Anesthesia complications? | ☐ ☐ | |
| Sleep Apnea | ☐ ☐ | CPAP? Yes/No: |
| Excessive bleeding problems? | ☐ ☐ | |
| Taking Aspirin, Motrin, Advil, Etc. | ☐ ☐ | |
| High blood pressure? | ☐ ☐ | |

**PAST SURGICAL PROCEDURES WITH DATES**

**MEDICATION ALLERGIES** **NONE KNOWN** ☐

**CURRENT MEDICATIONS: PRESCRIPTION AND OVER-THE-COUNTER**

| MEDICATION | DOSE | FREQUENCY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

| PERSONAL HABITS | Yes/No | FREQUENCY |
|---|---|---|
| Tobacco | ☐ ☐ | |
| Alcohol | ☐ ☐ | |
| Recreational Drugs | ☐ ☐ | |
| Exercise | ☐ ☐ | |
| Occupation | ☐ ☐ | Specify type: |
| Any history of cold sores? | ☐ ☐ | |

NUMBER OF PREGNANCIES _____ NUMBER OF CHILDREN _____

WEIGHT LOSS SURGERY? YES NO (If no, skip to Signature Line)

IF YES, WHEN? _____ BY WHOM? _____

COMPLICATIONS? YES NO EXPLAIN: _____

WEIGHT PRIOR TO SURGERY _____ PANT/DRESS SIZE PRIOR TO SURGERY _____

LOWEST WEIGHT AFTER SURGERY _____ PANT/DRESS SIZE AFTER SURGERY _____

DO YOU HAVE ABDOMINAL HERNIAS? YES NO IF YES, SPECIFY _____

HAVE YOU HAD ANY HERNIA REPAIRS? YES NO IF YES, SPECIFY _____

CURRENT BRA SIZE _____ DESIRED BRA SIZE _____ SIZE PRIOR TO PREGNANCY _____ SIZE DURING PREGNANCY _____

| HISTORY OF | Yes/No | SPECIFY |
|---|---|---|
| Shoulder pain | ☐ ☐ | |
| Shoulder grooving | ☐ ☐ | |
| Breast pain | ☐ ☐ | |
| Numbness of hands/fingers | ☐ ☐ | |
| Neck pain | ☐ ☐ | |

| | Yes/No | |
|---|---|---|
| Upper Back Pain | ☐ ☐ | |
| Inframammary Rashes | ☐ ☐ | |
| Family history of breast cancer | ☐ ☐ | |
| Mammograms | ☐ ☐ | When: Result: |
| Trauma/Injury to breasts | ☐ ☐ | |
| Infections in breasts (Mastitis) | ☐ ☐ | |
| Breast feeding | ☐ ☐ | |

*I ACKNOWLEDGE THAT THE ABOVE INFORMATION IN COMPLETE & ACCURATE TO THE BEST OF MY KNOWLEDGE*
SIGNATURE _____ DATE _____

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