

*Mehdi K. Mazaheri, MD, PC*

**Breast History Form**

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

1. What is your particular breast problem? \_\_\_\_\_
2. Does this run in female members of your family? YES NO
3. What is your height? \_\_\_\_\_ Weight? \_\_\_\_\_
4. What bra size do you wear? \_\_\_\_\_ Padded or unpadded? \_\_\_\_\_
5. What is your DESIRED breast size? \_\_\_\_\_
6. How many children do you have? \_\_\_\_\_ What are their ages? \_\_\_\_\_
7. Did your breasts change with pregnancy? YES NO
8. Did you breast feed? \_\_\_\_\_ Bottle feed? \_\_\_\_\_ Out of choice? \_\_\_\_\_
9. Have you ever had any breast disease or breast tumors? YES NO
10. Have you had a mammogram in the past? YES NO  
If yes, where and when? \_\_\_\_\_
11. Have you ever had a breast reduction, enlargement or lift? YES NO  
If yes, please list doctor and the date: \_\_\_\_\_
12. Have you ever had any of the following breast problems?
  - Nipple Discharge
  - Breast Lumps (or breast cysts)
  - Breast Trauma
  - Breast Infection (mastitis)
  - Inverted nipples
  - Breast Pain or Swelling
13. Are you taking birth control pills or receiving estrogen shots? YES NO
14. If you were treated for breast cancer, did you receive chemotherapy or radiation? \_\_\_\_\_

I signify that the information provided is correct to the best of my knowledge.

Signature: \_\_\_\_\_