Breast History Form

1. What is your particular breast problem? _____
   _____
2. Does this problem run in female members of your family? □ Yes □ No
   If so, who? _____
3. What is your: Height? _____ Weight? _____
4. What bra size do you wear? _____
   □ Padded □ Unpadded
5. How many children do you have? _____
   What are their ages? _____
   Did you breast feed? □ Yes □ No □ N/A
   Did your breasts change in size after pregnancy? □ Yes □ No □ N/A
   If so, what change in bra size occurred? _____
6. Have you ever had any breast diseases/breast tumors? □ Yes □ No
   If so, please specify: _____
   Surgery: _____
   Date: _____
   Doctor: _____
7. Has anyone in your family ever had any breast diseases/breast tumors? □ Yes □ No
   If so, please specify: _____
8. When was your last mammogram? _____
   Where? _____
9. Are you currently taking: -Birth control pills? □ Yes □ No - Hormone replacement therapy? □ Yes □ No
10. If you are a breast reduction candidate, have your ever been treated for this condition in the past by a physician or chiropractor specifically with:
    □ Medications/Prescriptions
    How long and which medications?_____
    □ Adjustments
    Duration of Treatments_____
    □ Support garments
    □ Other
    Please specify: _____
    _____

Signature: _____ Date: _____

Print Name:_____