BAJAJ PLASTIC SURGERY * 6205 N SANTA FE #105 * OKLAHOMA CITY, OK 73118 405-810-8448

PATIENT BREAST INFORMATION

Patient Name:_____ **Date:** _____
Birthdate: _____ **Social Security Number:** _____

Do you smoke: YES ( ) NO ( ) **How many packs per day:** _____
If you do smoke, have you tried to quit: YES () NO () Please explain: _____

_____

Reason for Visit:
Breast Symptoms*:* (if applicable)

Unsatisfactory Appearance _____	Breast Pain _____	Nipple Discharge _____
Implant Problems _____	Upper BackPain _____	Rashes _____
Neck Pain _____	Lower Back Pain _____	Infections _____
Absence of Breast/Nipple _____	Shoulder Pain _____	
Breast Mass/Lump _____		

Breast Surgery History:

Procedures:	Date	Location	MD

Breast Cancer Treatment:
Radiation Therapy: Yes ( ) No ( ) Date Completed _____
Chemotherapy YES ( ) NO ( ) Date Completed _____

Other: _____

Mammograms:

Date	Location	Findings

Family History Breast Conditions:

_____

_____

_____

Breast Implant: **Do you currently have implants? Yes _____ No _____**

Type: Saline ____ Silicone Gel ____ Size in CC's: _____

Position: Under muscle _____ Over muscle _____

Manufacturer: _____

_____
Patient Signature **Date**