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Breast Reduction Intake Sheet

DEMOGRAPHIC DATA

NAME: _____ DATE: _____

MEDICARE NUMBER: _____

PRIMARY INSURANCE: _____

SECONDARY INSURANCE: _____

REFERRING M.D.: _____

ADDRESS: _____

PRIMARY CARE M.D.: _____

ADDRESS: _____

HISTORY

SMOKE: Yes / No If Yes, how much? _____

DRINK: Yes / No If Yes, how much? _____

MEDICAL PROBLEMS: _____

MEDICATIONS: _____

NON-PRESCRIPTION MEDICATIONS (Including aspirin, Tylenol, Advil)

ORAL CONTRACEPTIVES: Yes / No

NUMBER PREGNANCIES: _____ NUMBER CHILDREN: _____

ABLE TO BREAST FEED: Yes / No

PLAN FOR FURTHER PREGNANCIES: Yes / No

FERTILE: Yes / No

BRA SIZE PRIOR TO PREGNANCY: _____

BRA SIZE NOW: _____ DESIRED BRA SIZE: _____

FAMILY HISTORY OF BREAST CARCINOMA: Yes / No

If yes: RELATIVE: MOTHER _____ SISTER _____
MGM _____ PGM _____

PREVIOUS BREAST SURGERY: _____

If yes, Date: _____ Procedure: _____ Surgeon: _____

DATE OF LAST MAMMOGRAM: _____ RESULT: _____

NIPPLE SENSATION: Normal _____ Diminished _____

SYMPTOMS

RASHES UNDER BREASTS: _____ ULCERATIONS UNDER BREASTS: _____

MEDICATIONS USED FOR ABOVE: _____

NUMBNESS IN RING OR LITTLE FINGERS: Yes / No

If yes, which side? Right: _____ Left: _____ Bilateral: _____

SHOULDER GROOVING: Yes / No

PAIN: Site Yes No

Breast	_____	_____
Chest	_____	_____
Shoulders	_____	_____
Cervical spine	_____	_____
Thoracic spine	_____	_____
Lumbar spine	_____	_____
Other site	_____	_____

If yes to any of the above, please answer the following:

Did any of the symptoms prevent you from performing personal duties? Yes / No

Did any of the symptoms prevent you from performing work? Yes / No

If yes, how much time was lost from work: _____

Can you provide documentation of lost time from work? Yes / No

ADDITIONAL SYMPTOMS: _____

PREVIOUS TREATMENT

HAVE YOU BEEN TREATED BY ANOTHER CAREGIVER FOR THIS PROBLEM?

If yes, Physician Name: _____

Address: _____

Description and duration of treatment: _____

Was there an improvement in symptoms? Yes / No

If yes, Chiropractor Name: _____
Address: _____
Description and duration of treatment: _____

Was there an improvement in symptoms? Yes / No

If yes, Physical therapy Name: _____
Address: _____
Description and duration of treatment: _____

Was there an improvement in symptoms? Yes / No

WT REDUCTION: Yes / No AMOUNT LOST: _____ lbs. DATE: _____
If yes, was this a formal weight reduction program? Yes / No
If yes, did this improve symptoms? Yes / No

WIDE STRAP BRA: Yes / No If yes, did this improve symptoms? Yes / No
ANALGESICS: Yes / No If yes, did this improve symptoms? Yes / No

PHYSICAL EXAM

AGE: _____ HEIGHT: _____ WEIGHT: _____

ABNORMAL MASSES: Yes / No LOCATION: _____

LARGER BREAST: RIGHT _____ LEFT _____

SYMMETRY: GOOD _____ FAIR _____ POOR _____

PROPORTIONALITY TO BODY HABITUS:
PROPORTIONATE: _____ DISPROPORTIONATE: _____

NIPPLE SENSATION GROSSLY INTACT: RIGHT: Yes / No LEFT: Yes / No
SKIN INTEGRITY - INTACT: Yes / No

SITE OF PROBLEM: _____

DESCRIPTION: _____

SCARS: _____

MEASUREMENTS:

CLAVICLE TO NIPPLE: R _____ L _____

STERNAL NOTCH TO NIPPLE: R _____ L _____

NIPPLE TO IMF: R _____ L _____

ALTERATION IN NORMAL THORACIC SPINE CURVATURE DUE TO MACROMASTIA:

Kyphosis: _____ Compensatory lordosis: _____ Scoliosis: _____

DIAGNOSES:

611.1 Bilateral mammary hypertrophy

695.89 - Intertrigo

724.2 - Low back pain

723.1 - Pain in neck

611.71 - Mastodynia

723.9 - shoulder strap grooving

TECHNIQUE

INFERIOR PEDICLE

SUPERIOR PEDICLE

FREE NIPPLE GRAFT