

# PATIENT BREAST AUGMENTATION QUESTIONNAIRE

(This information will be used by your doctor to help customize a breast procedure just for you)

## Your information

1. Name \_\_\_\_\_ 2. Occupation \_\_\_\_\_
3. Current height \_\_\_\_\_ 4. Current weight \_\_\_\_\_
5. Have you ever been pregnant?  No  Yes How many children have you had? \_\_\_\_\_
6. Did/do you breastfeed? (Please check one)  Yes  No
7. History of mastitis (inflammation of the breast tissue that results in breast pain and swelling)?  
 Yes  No
8. History or family history of breast cancer?  Yes  No
9. What is your activity level? (Please circle a number from 1 to 10)
- | Not very active |   |   | Moderately active |   |   |   | Very active |   |    |
|-----------------|---|---|-------------------|---|---|---|-------------|---|----|
| 1               | 2 | 3 | 4                 | 5 | 6 | 7 | 8           | 9 | 10 |
10. How long have you been considering a breast lift and/or breast augmentation? (Please check one)  
 > 6 months  > 1 year  > 2 years  > 3 years  > 4 years  > 5 years
11. What is motivating you to have your breast consultation at this time?  
\_\_\_\_\_  
\_\_\_\_\_

## Your desires and goals

12. What concerns do you have with your breasts? (Check all that apply)  
 Asymmetrical  Drooping  Loss of volume  Misshapen  Nipple drooping/too low  
 Sagging  Too big  Too small
13. Check all the words below that describe the look you want from your breast surgery:  
 Anatomical or teardrop  Lifted  Natural looking  Noticeable  Perky  Subtle  
 Symmetrical  Youthful
14. Are you interested in breast implants as part of your breast surgery? (If no, proceed to Question 22)  
 Yes  No
15. Are you requesting an augmentation to (Please circle one): Increase your volume  
Correct your breast shape
16. What type of look do you desire in terms of the size of your augmentation?  
(Please circle a number from 1 to 10)

Smaller					Larger				
1	2	3	4	5	6	7	8	9	10

Please continue on back.

# PATIENT BREAST AUGMENTATION QUESTIONNAIRE (continued)

(This information will be used by your doctor to help customize a breast procedure just for you)

17. What shape is more attractive to you? (Please check one of the examples below)

Natural and anatomical

Enhanced and round

18. Would you be willing to accept a slightly firmer feel if it meant maintaining a lasting shape?

Yes  No

19. Do you have an interest in any specific type of implant? (Please check all that apply)

Highly cohesive silicone gel  Saline  Silicone gel

20. What terms have you heard to describe the shape of breast implants?

(Please check all that apply)

Anatomical  Curved  Gummy bear  Round  Shaped  Teardrop

## Your concerns

21. On a scale from 1 to 10, how concerned are you about safety? (Please circle a number from 1 to 10)

Extremely unconcerned			Neutral				Extremely concerned		
1	2	3	4	5	6	7	8	9	10

22. How long do you expect your breast implants to last?

1-3 years  4-6 years  7-9 years  > 10 years

23. On a scale from 1 to 10, how important is cost when compared to having the look and shape that you desire from your breast surgery? (Please circle a number from 1 to 10)

Not important			Moderately important				Very important		
1	2	3	4	5	6	7	8	9	10

24. Are you interested in financing options available through our office?

Yes  No

25. Please use the space below to tell us anything else that you feel is important for us to know.

---

---

---

---

**Your surgeon will meet with you shortly.**