



Children's Hospital Boston
Adolescent Breast Clinic
Department of Plastic Surgery
Intake Form

Name		Date of Birth	
Today's Date		Height	
Age		Weight	
1. Reason for your visit to the Adolescent Breast Center:			
2. Have you ever been treated for this problem before?			<input type="checkbox"/> yes <input type="checkbox"/> no
If yes:	When?		
3. Please list your current symptoms:			
4. Has your weight changed substantially over the past 6 months?			<input type="checkbox"/> yes <input type="checkbox"/> no
If yes:	Have you gained or lost weight?		<input type="checkbox"/> gained <input type="checkbox"/> lost
	How much weight have you gained or lost?		
	Were you trying to change your weight?		<input type="checkbox"/> yes <input type="checkbox"/> no
5. Age when you first noticed breast growth:			
6. How would you rate your current satisfaction?			
<input type="checkbox"/> Very Satisfied (I wouldn't change anything about my appearance.)			
<input type="checkbox"/> Somewhat Satisfied (I would change one or two things about my appearance if I could.)			
What would you change and why?			
<input type="checkbox"/> Not At All Satisfied (I would change many things about my appearance if I could.)			
What would you change and why?			
7. Do you have any of the following? (please check your answer)			
a. Breast pain?			<input type="checkbox"/> yes <input type="checkbox"/> no
b. Breast lump?			<input type="checkbox"/> yes <input type="checkbox"/> no
c. Nipple discharge?			<input type="checkbox"/> yes <input type="checkbox"/> no
d. Back Pain?			<input type="checkbox"/> yes <input type="checkbox"/> no
If yes:	Please check your current pain level on a scale from 1 to 10 (1=mild pain, 10=severe pain)		
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10
e. Neck Pain?			<input type="checkbox"/> yes <input type="checkbox"/> no
If yes:	Please check your current pain level on a scale from 1 to 10 (1=mild pain, 10=severe pain)		
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10
f. Shoulder Pain?			<input type="checkbox"/> yes <input type="checkbox"/> no
If yes:	Please check your current pain level on a scale from 1 to 10 (1=mild pain, 10=severe pain)		
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10
g. Rashes/skin breakdown around or underneath breasts?			<input type="checkbox"/> yes <input type="checkbox"/> no



Children's Hospital Boston
Adolescent Breast Clinic
Department of Plastic Surgery
Intake Form

h. Significant difference in breast size?		<input type="checkbox"/> yes	<input type="checkbox"/> no
i. Difficulty participating in sports?		<input type="checkbox"/> yes	<input type="checkbox"/> no
j. Difficulty finding clothes that fit properly?		<input type="checkbox"/> yes	<input type="checkbox"/> no
k. Eating disorder?		<input type="checkbox"/> yes	<input type="checkbox"/> no
If yes:	Please check or write in which one you have been diagnosed with or which symptoms you have:		
	<input type="checkbox"/> Anorexia nervosa		
	<input type="checkbox"/> Bulimia		
	<input type="checkbox"/> Binge eating disorder		
<input type="checkbox"/> Other:			
l. Frequent weight changes?		<input type="checkbox"/> yes	<input type="checkbox"/> no
m. Depression?		<input type="checkbox"/> yes	<input type="checkbox"/> no
n. Anxiety?		<input type="checkbox"/> yes	<input type="checkbox"/> no
8. Family history:			
a. Are there any family members (male or female) with breast problems?		<input type="checkbox"/> yes	<input type="checkbox"/> no
If yes:	Specify who:		
b. Has anyone in your family ever had breast surgery?		<input type="checkbox"/> yes	<input type="checkbox"/> no
c. Has anyone in your family been diagnosed with breast cancer?		<input type="checkbox"/> yes	<input type="checkbox"/> no
If yes:	Specify who and age at diagnosis:		
Past Medical History:			
9. Have you ever been hospitalized?		<input type="checkbox"/> yes	<input type="checkbox"/> no
If yes:	When and why?		
10. General:			
a. Fevers?		<input type="checkbox"/> yes	<input type="checkbox"/> no
b. Night sweats?		<input type="checkbox"/> yes	<input type="checkbox"/> no
11. Head/Ears/Eyes/Nose/Throat/Neck:			
a. Headaches?		<input type="checkbox"/> yes	<input type="checkbox"/> no
b. Dizziness?		<input type="checkbox"/> yes	<input type="checkbox"/> no
c. Problems with vision/blurry vision?		<input type="checkbox"/> yes	<input type="checkbox"/> no
d. Problems with hearing/deafness?		<input type="checkbox"/> yes	<input type="checkbox"/> no
e. Frequent throat or ear infections?		<input type="checkbox"/> yes	<input type="checkbox"/> no
f. Nosebleeds, bleeding of gums?		<input type="checkbox"/> yes	<input type="checkbox"/> no
12. Skin:			
a. Rashes, Itching?		<input type="checkbox"/> yes	<input type="checkbox"/> no
13. Cardio-Pulmonary:			
a. Irregular heart beat/palpitations		<input type="checkbox"/> yes	<input type="checkbox"/> no
b. Fainting spells		<input type="checkbox"/> yes	<input type="checkbox"/> no
c. Chest pain		<input type="checkbox"/> yes	<input type="checkbox"/> no
d. Shortness of breath		<input type="checkbox"/> yes	<input type="checkbox"/> no
e. Persistent cough		<input type="checkbox"/> yes	<input type="checkbox"/> no
14. Gastrointestinal:			
a. Diarrhea or constipation		<input type="checkbox"/> yes	<input type="checkbox"/> no
b. Nausea or vomiting		<input type="checkbox"/> yes	<input type="checkbox"/> no
c. Abdominal pain		<input type="checkbox"/> yes	<input type="checkbox"/> no



Children's Hospital Boston
Adolescent Breast Clinic
Department of Plastic Surgery
Intake Form

d. Decreased or increased appetite	<input type="checkbox"/> yes	<input type="checkbox"/> no
15. Genitourinary:		
a. Pain or burning with urination	<input type="checkbox"/> yes	<input type="checkbox"/> no
b. Frequent urination	<input type="checkbox"/> yes	<input type="checkbox"/> no
c. Urinary tract infections	<input type="checkbox"/> yes	<input type="checkbox"/> no
d. Sexually transmitted disease(s)	<input type="checkbox"/> yes	<input type="checkbox"/> no
e. Vaginal discharge	<input type="checkbox"/> yes	<input type="checkbox"/> no
16. Musculoskeletal:		
a. Back, neck or shoulder pain	<input type="checkbox"/> yes	<input type="checkbox"/> no
b. Leg pain	<input type="checkbox"/> yes	<input type="checkbox"/> no
c. Difficulty walking	<input type="checkbox"/> yes	<input type="checkbox"/> no
17. Psychiatric:		
a. Have you ever been under the care of a psychiatrist or therapist?	<input type="checkbox"/> yes	<input type="checkbox"/> no
b. If yes, when and why?		
c. Have you ever had thoughts of wanting to harm yourself?	<input type="checkbox"/> yes	<input type="checkbox"/> no
d. Have you ever attempted to harm yourself?	<input type="checkbox"/> yes	<input type="checkbox"/> no
18. Medications:		
a. Do you take any medications?	<input type="checkbox"/> yes	<input type="checkbox"/> no
If yes:	Please list them here:	
b. Do you have any allergies to medications or food	<input type="checkbox"/> yes	<input type="checkbox"/> no
If yes:	Please list them here, along with the type of reaction:	
19. Social history:		
a. What grade are you in at school?		
b. What kinds of grades do you get?	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> F	
c. Do you smoke cigarettes?	<input type="checkbox"/> yes	<input type="checkbox"/> no
If yes:	How many cigarettes per week?	
d. Do you drink alcohol?	<input type="checkbox"/> yes	<input type="checkbox"/> no
If yes:	How many drinks per week?	
e. Do you or have you ever done illicit drugs (marijuana, cocaine, ect.)?	<input type="checkbox"/> yes	<input type="checkbox"/> no
If yes:	Which substance and when was the last time?	
f. Have you ever used intravenous drugs?	<input type="checkbox"/> yes	<input type="checkbox"/> no
g. Do you have any tattoos?	<input type="checkbox"/> yes	<input type="checkbox"/> no
h. Do you have any children?	<input type="checkbox"/> yes	<input type="checkbox"/> no

If you are a female, please answer the following questions.

20. Bra information:		
a. Current bra size:		
b. How long have you been wearing this size?		
c. Do you have difficulty finding bras that fit properly?	<input type="checkbox"/> yes	<input type="checkbox"/> no
d. Have you ever been professionally fitted for a bra?	<input type="checkbox"/> yes	<input type="checkbox"/> no
21. Menstruation:		
a. Age at first menstrual period:		
b. Date of your last menstrual period:		
c. Irregular menstrual periods/heavy menstrual periods?	<input type="checkbox"/> yes	<input type="checkbox"/> no
22. Have you ever been pregnant?	<input type="checkbox"/> yes	<input type="checkbox"/> no