



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

Name		Date of Birth	
Today's Date		Height	
Age		Weight	
1. Reason for your visit to the Adolescent Breast Center:			
2. Please list your current symptoms, including any new symptoms:			
3. 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
4. Has anything changed in your medical history since the last time you were here?			<input type="checkbox"/> yes <input type="checkbox"/> no
If yes:	What?		
5. Have you had any operations since the last time you were here?			<input type="checkbox"/> yes <input type="checkbox"/> no
If yes:	What was the operation? (include date and place of operation)		
6. Have you ever been hospitalized since the last time you were here?			<input type="checkbox"/> yes <input type="checkbox"/> no
If yes:	When and why?		
7. Do you take any medications?			<input type="checkbox"/> yes <input type="checkbox"/> no
If yes:	Please list them here: (including any new medications)		

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

8. What was the date of your last menstrual period:			
9. Since you were here last time, have you ever been pregnant or had a child?	<input type="checkbox"/> yes	<input type="checkbox"/> no	