Gynecomastia Male Breast Surgery Consultation Dean P Kane, MD, FACS, PA

Name: _____ Age:_____ Date:_____

Thank you for choosing our office for your consultation! Please check or fill in the following information so I may better help you.

Height:____, **Weight**:____.

Have you had breast cancer? Yes No. Any **family with breast cancer?** Male or Female? None

List and date any prior UltraSound or **Mammograms**: WHERE and WHEN

Age: _____, Findings:

List and date any prior **Breast Surgery or Injury**:

Age: _____, Findings:

Circle if related to you: Undescended testicle, testicle tumor, liver disease.

Have you ever **used**: marijuana, H2 blocker, dilantin, digoxin, DES, ketoconazole, alcohol, spironolactone, lupron,anti--depressants, valium

Your Concerns:	0 Other concerns:
0 Nipple Areola size / protrusion 0 Breast Mound size 0 Chest Wall fullness 0 Breast Rolls 0 Breast Fold	