CHEST MASCULINIZATION WORKSHEET

Date:_____

PATIENT DATA

Legal Name:_____ Chosen Name:_____
Pronouns:_____
Height:_____ Current Weight:_____ Goal Weight:_____

Number of Pregnancies:_____ Number of births:_____
Are You Planning To Have Future Pregnancies? Yes No
Are You Planning To Breastfeed? Yes No

Are you on testosterone? _____ When was the date you started? _____

BREAST SYMPTOMS – check all that apply, if any

- ☐ Back Pain
- ☐ Neck Pain
- ☐ Breast Pain
- ☐ Other: _____
- ☐ Difficulty with Clothing
- ☐ Difficulty with Posture
- ☐ Difficulty with Exercising
- ☐ Skin Irritation/Intertrigo/Rashes
- ☐ Nipple Bleeding
- ☐ Nipple Discharge

ONCOLOGIC INFORMATION

Breast Cancer? Yes (Family) (Personal) No
History of Other Cancers:_____
Prior Breast Surgeries?_____
Prior Breast Biopsies or Masses?_____
Latest Mammogram, if any?_____ Any Mammogram Abnormalities?_____

EXPECTATIONS:

Bra size (when last worn):_____
Do you use a binder? Or other? _____
Are there any asymmetries between your breasts? _____

What are your goals for your chest surgery?_____
_____
_____

Is there anything you wish to avoid with your chest surgery?_____
_____
_____

PLEASE LIST ANYTHING ELSE YOU WOULD LIKE US TO KNOW:

_____
_____