

BREAST REDUCTION PATIENT QUESTIONNAIRE

Please complete the following questionnaire that will assist us in obtaining the necessary information to submit to your insurance for your breast reduction. Thank you for being as detailed as possible.

NAME: _____ BIRTHDATE: _____

HEIGHT: _____ WEIGHT: _____

Reason for visit: _____

Present bra size: _____

Desired cup size: _____

Why are you interested in this surgery? _____

YES NO

1. Have you seen another physician regarding this procedure?
(Please specify the name of physician.) _____

2. Are your breasts the same size?
Which is smaller? _____

3. Do you have or have you ever had breast discomfort, pain,
soreness, swelling or nipple discharge? (Specify which.) _____

4. Do you suffer from any of the following?

a. Shoulder pain

b. Neck pain

c. Back pain

5. Do your breasts affect your activities? How?
(Difficulty running, walking, affects self esteem, etc.) _____

6. Have you taken any prescribed or over-the-counter pain
medication? (Please specify dose and medication.) _____

7. Have you tried acupuncture for pain relief?
(Please specify duration of treatment.) _____

8. Previous breast surgery or biopsies?
(Please specify location and dates.) _____

9. Do you have a lump in your breast?
(Specify which breast.) _____

How discovered? _____

When discovered? _____

How treated? _____

10. Is there any family history of breast cancer on mother's side of family? (Please specify relative.) _____

11. Do you have shoulder grooving? _____

12. Have you made any attempt to treat this problem using any of the following?

a. Specialty bras to help support breasts? (wide straps, etc.) _____

b. Have you visited a physical therapist to alleviate your condition? _____

c. Have you visited a nutritionist for weight loss? (How long was treatment and how much weight lost?) _____

13. Have you visited a chiropractor? If so, who? (Please specify duration of treatment.) _____

14. Do you have or have you suffered from a rash under the folds of the breast? (How often and how long?) _____

15. Have you used any antibiotics, powders or creams to help alleviate these irritations? (Please specify medication and duration of treatment.) _____

16. Are you currently menstruating? If so, please specify age of onset and date of last menstruation. _____

17. Is your menstruation cycle regular? (Please specify how often you menstruate.) _____

18. Do you have any children? (Please specify how many and their ages.) _____

19. Did you breast feed any of your children? _____