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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 ever seen another physician regarding this procedure?
(Please specify the name of the 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? if yes, how long? _____

☐ ☐ b) Neck pain? if yes, how long? _____

☐ ☐ c) Back pain? if yes, how long? _____

☐ ☐ d) Headaches? if yes, how long? _____

☐ ☐ e) Numbness of fingers? if yes, how long? _____

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

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

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

BREAST REDUCTION PATIENT QUESTIONNAIRE (continued)

YES NO

☐ ☐ 8) Have you consulted an Orthopedic, Neurosurgeon, or Neurologist? _____
(Please specify names and dates) _____

☐ ☐ 9) Have you had any previous breast surgery or biopsies? _____
(Please specify location & dates) _____

☐ ☐ 10) Do you have any lumps in your breasts? (Please specify which breast) _____
How was it discovered? _____
When was it discovered?_____
How was it treated? _____

☐ ☐ 11) Have you had radiation therapy on either breast ? if yes, which one?_____

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

☐ ☐ 13) Do you have bra strap grooving?

☐ ☐ 14) 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? _____
(Please specify dates/ length of treatment/ and where?_____

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

☐ ☐ 15) Have you visited a Chiropractor? If so, who?_____
(Please specify duration of treatment)_____

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

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

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

☐ ☐ 19) Is your menstruation cycle regular? (Please specify how often)_____

☐ ☐ 20) Do you have any children? (Please specify how many and ages) _____

☐ ☐ 21) Did you breast feed your children?

☐ ☐ 22) Have you had a mammogram? (Please specify date and facility)_____
_____