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?