

Breast Reduction Questionnaire

What are your symptoms related to your breasts? (please circle all that applies)

**Breast pain shoulder grooving upper back pain mid back pain
 lower back pain neck pain shoulder pain Rashes**

Other: _____

Have you had any previous treatment? _____

Have you seen you primary doctor for this problem? _____

Have you taken any prescription drugs relating to you your symptoms? _____

Which prescriptions? _____

Did this help? _____ complete relief / moderate relief/ minimal relief/ no relief

Have you taken any over the counter medications for this problem? _____

Which medications? _____

Did this help? _____ complete relief / moderate relief/ minimal relief/ no relief

Have you seen a physical therapist? _____ If so, was this helpful? _____

Have you seen a chiropractor? _____ If so, was this helpful? _____

Height _____ Weight _____ Bra size _____

Number of Children: _____ ages: _____ Did you breast feed? _____

Are you planning additional pregnancies? _____

Have you seen anyone else for this problem? _____

Any family history of breast cancer or breast disease? _____

Have you had any breast lumps, masses or cysts? _____

Have you have had breast cancer? _____

When was your last mammogram? _____ Was it normal? _____

(Below is for office use only)

_____ Masses/LAD

_____ Skin Tone

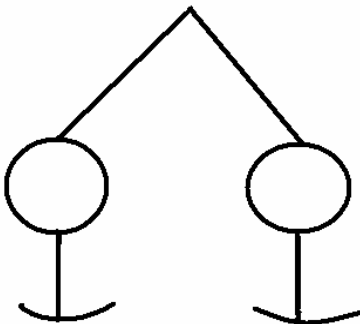
_____ Ptosis Gr I/II/III

_____ Asymmetry

_____ Lateral Chest wall

_____ Grooving

_____ Inframmary skin



Estimated grams of tissue to be removed: Right _____ Left _____