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Board-Certified Plastic Surgeon
Cosmetic and Reconstructive Surgery

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Board-Certified Otolaryngologist
Facial Plastic Surgery

# Breast Reduction Questionnaire

Patient's Name______________________________________________________________

Age______________ Weight_______________ Height___________________

Bra Size______________________________________

Symptoms:
Upper Back Pain________
Lower Back Pain________ Shoulder Grooving________
Neck Pain___________ Rashes under breasts________
Shoulder Pain________ Restrictions of Physical activities________
Other ____________________________________________________________________
__________________________________________________________________________

How lomg have these symptoms been present? ______________________________________
How do these symptoms interfere with your daily activities _________________________
__________________________________________________________________________

Have you ever seen another doctor for this problem Y N
Name of Doctor______________________________________________________________

Have you ever had x-rays taken of you're: back______ neck______ shoulder_______
When where these x-rays taken?___________________________________________

Pain relief measures: (pain medication, muscle relaxers, creams, heat…)_________________
__________________________________________________________________________
__________________________________________________________________________

Have you every attended Physical Therapy in regards to your symptoms? Y N
When?_____________________________________________________________________

Are you currently attempting to lose weight? Y N
What measures are you taking?_______________________________________________

Please list the age of all children_____________________________________________
Have you breastfed in the past?______________________________________________

Is there any history of breast cancer in your family?______________________________
If yes, who?_______________________________________________________________

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