burt & will

PLASTIC SURGERY AND LASER CENTRE

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 long 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 on any of the following? back_____ neck_____ shoulder_____

When where these x-rays taken? _____

Pain relief measures: (pain medication, muscle relaxers, creams, heat,etc.)

_____

_____

Have you ever 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? Y N

Is there any history of breast cancer in your family? Y N

If Yes, who? _____