

PATIENT NAME \_\_\_\_\_

**BREAST REDUCTION QUESTIONNAIRE**

AGE: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ BRA SIZE: \_\_\_\_\_

**SYMPTOMS:**

- Upper Back Pain
- Lower Back Pain
- Neck Pain
- Shoulder Pain
- Shoulder Grooving
- Rashes Under Breasts
- Restrictions of Physical Activity
- Other: \_\_\_\_\_

How long have these symptoms been present? \_\_\_\_\_

How do these symptoms interfere with your daily activities? \_\_\_\_\_

Have you seen another doctor for this problem?  YES  NO

Name of previously seen doctor: \_\_\_\_\_

Have you ever had x-rays taken on any of the following?  BACK  NECK  SHOULDER

When were these x-rays taken? \_\_\_\_\_

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

Have you ever attended Physical Therapy or seen a Chiropractor in regards to your symptoms?  YES  NO

When? \_\_\_\_\_

Are you currently attempting to lose weight?  YES  NO

What measures are you taking? \_\_\_\_\_

Please list the age of all children: \_\_\_\_\_

Have you breastfed in the past?  YES  NO

Is there any history of breast cancer in your family?  YES  NO

If yes, who? \_\_\_\_\_