Burt & Will Plastic Surgery and Dermatology Patient Registration | Date: _____

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? _____