Pooler Plastic Surgery

BREAST REDUCTION QUESTIONNAIRE

Name:______________________________ Date:__________

Age: __________ Height: __________ Weight: __________ Bra Size:__________

Age at breast development: __________ Weight loss in last year: __________

Pregnancies: __________ Miscarriages: __________ Children: __________

Did you breastfeed? □ Yes □ No If yes, how long? __________

1. Which of the following do you have? (Please check all that apply)

□ Enlarged Breast □ Breast Pain □ Breast asymmetry
□ Breast masses □ Bra strap indentation □ Difficulty examining your breast
□ Fibrocystic breasts □ Finger or hand numbness □ Neck pain
□ Nipple discharge □ Lower back pain □ Upper back pain
□ Rash beneath your breasts □ Poor posture □ Shoulder pain
□ Blisters under breasts □ Headache at top of neck □ Arm pain

2. Which of the following have you tried for relief? (Please check all that apply)

□ Heating pad □ Aspirin □ Tylenol □ Motrin □ Advil □ Creams □ Massages
□ Diet □ Binders □ Chiropractor □ Lineaments □ Traction □ Support bra
□ Neck brace □ Prescription medication □ Other over the counter medications: __________

3. How effective have these treatments been?

□ None □ Slight □ Fairly good □ Good □ Great □ Total relief

4. What does your breast size interfere with you doing?

□ Swim □ Yard work □ Household work □ Employment duties □ Sports □ Exercise □ Sex
□ Other: ______________________________

5. Exercises you do? ______________________________
6. What have you done to lose weight? ______________________________
7. How long have you considered reducing the size of your breasts?______________________________
8. How long have you had these symptoms? □ Weeks □ Months □ Year □ Many years
9. Do you have a family history of large breasts? □ Yes □ No
10. Date of your last menstrual period: __________
11. Do your breast change in size around the time of your period? □ Yes □ No

12. Do you practice monthly breast self-examinations? ☐ Yes ☐ No

13. What was the date of your last mammogram: ______________ Results: ____________________

14. Have you had any previous breast surgery? ☐ Yes ☐ No

Type: ____ Date: ________________________

Results: ____

15.Do you have any family history of breast cancer? ☐ Yes ☐ No

Relationship: ____________________ Approximate age: _______Status:___________________________

16. Do you smoke cigarettes or use other tobacco? ☐ Yes ☐ No ☐ Past Other: ______________________

If yes, how much? _________________________ How long? ______________________________

17. Do you take aspirin or aspirin-containing products? ☐ Yes ☐ No Product: _______________________

18. Do you take steroids? ☐ Yes ☐ No

19. Do you scar poorly? ☐ Yes ☐ No

20. Do you have diabetes? ☐ Yes ☐ No

21. Do you have high blood pressure? ☐ Yes ☐ No

22. Are you presently under the care of a physician? ☐ Yes ☐ No Physician: _____________________

23. Do you have difficulty healing wounds? ☐ Yes ☐ No

24. What is your highest and lowest weight in the last 12 months? ________________________________

Most breast reduction surgery is covered by health insurance policies. The insurance companies require written reports from our office before making the determination.
This report will contain information you have provided on this form and the results of your examination. Photographs of your breasts, not your face, will also be taken and sent along with this report. It is entirely your choice if you would like us to prepare such a written report for pre-determination of your benefits.

Do you wish this office to prepare as insurance pre-determination report for payment of your breast reduction surgery? Yes ☐ No ☐

Do we have permission to send photographs of your breast (without your face) to your insurance company? Yes ☐ No ☐

__________________________________ ________________

Patient Name Date