

## BREAST REDUCTION QUESTIONNAIRE

We are sorry for the inconvenience and burden of additional paperwork; however, to comply with requests from insurance companies for more and more information to enable approval of this procedure, we must have you answer the following questions. Additional information may still be requested.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Children Y/N # of \_\_\_\_\_ Effects on Breast: \_\_\_\_\_

Does weight gain/loss affect breast size? \_\_\_\_\_

Previous Breast Disease/Surgery? \_\_\_\_\_

Last mammogram: \_\_\_\_\_ Where: \_\_\_\_\_ Results: \_\_\_\_\_

Family History of breast Cancer? \_\_\_\_\_

Motivation for Breast reduction surgery: \_\_\_\_\_

Current bra size: \_\_\_\_\_

Desired bra size: \_\_\_\_\_

SYMOTOMS: (Please check all that apply.)

- |   |  |
|---|--|
| <input type="checkbox"/> Shoulder Pain                    | <input type="checkbox"/> Shoulder Grooving |
| <input type="checkbox"/> Breast Asymmetry                 | <input type="checkbox"/> Upper Back Pain   |
| <input type="checkbox"/> Rash under/between Breasts       | <input type="checkbox"/> Lower Back Pain   |
| <input type="checkbox"/> Shoulder Irritation/Pigmentation | <input type="checkbox"/> Neck Pain         |
| <input type="checkbox"/> Numbness of Arms and/or Hands    |  |

**HISTORY:**

Have you been or currently being treated by a physician for any medical problems as a result of your large breast? ( ) yes ( ) no

Explain: \_\_\_\_\_

Have you tried diet and or exercise programs, physical therapy, chiropractic care, supportive bra for relief of symptoms?

Yes\_\_ No\_\_ Explain \_\_\_\_\_

Have you tried any over the counter or prescription medications for skin changes around breasts? ( ) yes ( ) no

Explain: \_\_\_\_\_

Describe how your large breasts interfere with your daily activities including work and exercise related and any other activities

\_\_\_\_\_

**FOR OFFICE USE ONLY:**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_

Sternal notch to nipple:	LEFT:	RIGHT:
Inframammary fold to nipple:	LEFT:	RIGHT:
Estimated grams to be removed:	LEFT:	RIGHT:
Symmetry	Stria	Previous scars
Ptosis	masses/tenderness	lateral fullness

Notes: \_\_\_\_\_

\_\_\_\_\_