BREAST REDUCTION QUESTIONNAIRE

Name____________________________________ Age________

Do you have any of the following: (Please check)
___Breast pain 611.1
___Shoulder pain..723.9
___Neck pain...723.1
___Upper back pain...724.1
___Lower back pain...724.2
___Rash beneath your breasts................................695.89
___Finger or hand numbness.................................354.2
___Bra strap indentation..
___Breast asymmetry...611.8
___Nipple discharge..
___Difficulty examining your breast.....................
___Fibrocystic breasts..610.0
___Breast masses..611.72
___Poor posture...

Do you have difficulty finding properly fitting clothing as a result of your large breasts? Yes____ No____

Do you have to limit your physical activities as a result of your large breast size?
Yes ____ No ____

Have you seen a physician, surgeon or chiropractor for treatment of back pain of problems related to your large breasts? Yes ____ No ____

Are you self-conscious about the size of your breast? Yes ____ No ____

How tall are you? _____________ How much do you weigh? __________

Largest bra size _______________

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. Polaroid photographs of your breast, and 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. Your insurance company will be billed if you ask us to prepare this report, which includes, the photos, the fax, the follow-up, the FedEx, etc.

____ ___________________
Signature of Patient Date

How long have you considered reducing the size of your breasts? _______________

Have any of your family members or friends undergone breast reduction surgery?
Yes ____ No ____
Relationship? ____________________ When? ___________ Where?____________
By whom? _______________________
Were they satisfied? Yes ____ No ____
Did they experience any problems? Yes ____ No ____
What kind of problems? ____
Do large breast run in your family? Yes ____ No ____
Date of your last menstrual period: _________________
Do your breast change in size around the time of your period? Yes ____ No ____
Do you practice monthly breast self-examinations? Yes ____ No ____
What was the date of your last mammogram? ____________ Results______________
Have you had any previous breast surgery? Yes ____ No ____ Type_____________
Date ________________ Results ____
Do you have any family history of breast cancer? Yes ____ No ____
Relationship ________________ Approximate age ______ Status ________________
How many children do you have? _______
Did you breast feed them? Yes ____ No ____ If yes, how long? _______________
Do you smoke cigarettes? Yes ____ No ____ Number of packs per day _________
Do you take aspirin or aspirin-containing products? Yes ____ No ____
Do you take steroids? Yes ____ No ____ Do you scar poorly? Yes ____ No ____
Do you have diabetes? Yes ____ No ____ Do you have high blood pressure?
Yes____ No____
Are you being treated for any autoimmune disorder? Yes ____ No ____
Are you presently under the care of a physician? Yes ____ No ____
Do you have difficulty healing wounds? Yes ____ No ____
What is your highest and lowest weight in the last 12 months? ___________

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 ____

YOUR INSURANCE COMPANY WILL BE BILLED FOR PREPARATION OF THIS REPORT AND THE PHOTOS.

___________________________________ ____________________
Signature Date