BREAST REDUCTION QUESTIONNAIRE

Name____ Age__________

Height______________ Weight__________________ Bra Size_____________

Do you have any of the following: (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
□ Poor posture	□ Rash beneath your breasts	□ Shoulder pain

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 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_______________________

Office Location_______________________________Physician ____________________

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? ________________________

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. The complimentary cosmetic consultation Does Not Cover the costs associated with insurance preparation pre-determination and billing. 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.

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 □

****If you answered "yes" to the 2 questions above, please provide us with an insurance card or copy of your insurance information, and complete all sections of this questionnaire. ****

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

____ ________________________
Signature Date