

BREAST REDUCTION PATIENT QUESTIONNAIRE

Please answer the following questions to the best of your knowledge. This will enable Dr. Cober to have as much information as possible to evaluate your needs. Thank you for your time.

Name: _____

Height: _____ Weight: _____ Bra Size: _____

Do you have any of the following symptoms: Back pain or neck pain?..... Yes No

If yes, where is the pain located? _____

Have you seen a physician or chiropractor for your pain?..... Yes No

If yes, name of physician or chiropractor: _____

Dates seen: (approximately) _____

Have you had physical therapy for your back? Yes No

If yes, name of the facility/physical therapist: _____

Date of treatment: _____

Do you now or have you ever taken in the past, any type of pain medication including prescription and over-the-counter pain or anti-inflammatory medication for your back pain symptoms? ... Yes No

If yes, please list the pain/anti-inflammatory medication that you have taken/are taking, approximate dates and frequency: _____

Do you currently exercise regularly? Yes No

If yes, please list the type(s) of exercise and frequency: _____

If no, does the weight/size of your breasts inhibit your ability to exercise? _____

Have you had a weight loss/gain in the past few years?..... Yes No

If yes, please specify amount of loss/gain: _____

Did this weight loss/gain affect your breast size? Yes No

If yes, please specify: _____

Do you have now, or have you had in the past, skin infections or skin breakdowns

between or under your breast? Yes No

If yes, has a physician or another health care professional treated you for these symptoms? ... Yes No

If you have not seen a physician or health care provider for these skin infections, have you self-treated with any over-the-counter products?..... Yes No

If yes, please list names of the products and frequency of use: _____

Do you have shoulder strap grooving? Yes No

Do you have to special order bras? Yes No

Does your breast size/weight inhibit your ability to perform normal duties at work or home? Yes No

If you have had children, did you breast feed? Yes No

Ages if children: _____

Do you have headaches?..... Yes No

If yes, how frequent? _____

Do you have numbness in your fingers? Yes No

If yes, which fingers, how frequent? _____

Date of your last mammogram: _____

Are your breasts equal in size? Yes No

If no, please describe: _____

Any personal history of lumps or prior biopsies? Yes No

If yes, please describe: _____

Any family history of breast cancer or other conditions? Yes No

If yes, please describe: _____

What is your occupation? _____