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? _____