

## BREAST REDUCTION QUESTIONNAIRE

Please answer the following questions, to help us better serve you, the patient. Thank You

Name: \_\_\_\_\_

1. Height: \_\_\_\_\_ Weight: \_\_\_\_\_

2. Bra size: \_\_\_\_\_

3. Describe symptoms: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

4. Do you have shoulder grooving? \_\_\_\_\_

5. Is there breakdown of skin under the breasts? \_\_\_\_\_

6. Duration of these symptoms: \_\_\_\_\_

7. Please list alternative methods tried to resolve these symptoms, including medications: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

8. Have you been seen by another physician or clinic for these symptoms, including PCP, Physical Therapy or Chiropractic Clinic? Please list:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_