

Texas Plastic Surgery Associates
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Breast Reduction Questionnaire

Please indicate which of the following symptoms you have experienced:

- | | |
|--|--|
| <input type="checkbox"/> Breast pain | <input type="checkbox"/> Shoulder pain |
| <input type="checkbox"/> Rashes beneath or between the breasts | <input type="checkbox"/> Arm numbness/tingling |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Upper back pain |
| <input type="checkbox"/> Shoulder grooving at bra straps | |

How long have you had these symptoms: _____

Have you had any of the following:

- | | |
|--|-----------------------------------|
| <input type="checkbox"/> Difficulty with physical activity or exercise | |
| <input type="checkbox"/> Recent weight gain If so, how much _____ | Did the breast size change? _____ |
| <input type="checkbox"/> Recent weight gain If so, how much _____ | Did the breast size change? _____ |
| <input type="checkbox"/> Mammogram If so, when _____ | Results _____ |
| <input type="checkbox"/> Breast mass/lump | |
| <input type="checkbox"/> Breast pain | |

Have you tried any of the following treatments?

- | | |
|--|---------------|
| <input type="checkbox"/> Ointments for the rashes | Result: _____ |
| <input type="checkbox"/> Over the counter pain medications | _____ |
| <input type="checkbox"/> Physical therapy for back/neck pain | _____ |
| <input type="checkbox"/> Prescription pain medications | _____ |
| <input type="checkbox"/> Support bras | _____ |
| <input type="checkbox"/> Prior surgeries | _____ |

Have you seen any other physicians for these symptoms? ___Yes ___No.

If yes, what is the name of the physician(s) and when were you seen: _____

Are you currently taking any of the following medications?

- | | |
|---|----------------------------------|
| <input type="checkbox"/> estrogens/hormones | Reason and who prescribed: _____ |
| <input type="checkbox"/> growth hormones | _____ |
| <input type="checkbox"/> steroids | _____ |

Have you ever been diagnosed with or experienced any of the following:

- | | |
|---|--|
| <input type="checkbox"/> fibrocystic breast disease | <input type="checkbox"/> trauma/injury to the breast |
| <input type="checkbox"/> cancer of the breast | <input type="checkbox"/> breast biopsy |
| <input type="checkbox"/> radiation treatment/exposure | |

Printed Name

Signature

Date