

FREDERICK J. DUFFY, JR. M.D., P.A.
Plastic and Reconstructive Surgery
Specializing in Microsurgery, General Reconstruction, and Surgery of the Hand

7777 Forest Lane, Suite C-504
Dallas, TX 75230

972-566-3939
FAX 972-566-3999

Breast Reduction Questionnaire

In order to assist us in understanding your medical history and provide information to your insurance company, please complete this questionnaire and bring it with you to your consultation appointment.

Please indicate which of the following symptoms you have experienced:

_____ Pain in the upper back, neck, and/or shoulders which is unrelated to other musculoskeletal causes (i.e. which is not related to posture, post traumatic conditions, arthritis, injury, etc.)

If you have the above, please indicate the specific locations of the pain: _____

Have you seen a physician for these pains? ___Yes ___ No If yes, what is the name of the physician and when were you seen? _____

_____ Persistent or frequent submammary (below the breasts) rashes, sores, or skin irritations

If you have the above, please indicate what treatments you have used for these skin problems: _____

Have you seen a physician for these? ___Yes ___ No If yes, what is the name of the physician and when were you seen? _____

_____ Periodic pain and/or numbness in the arms and/or hands (ulnar nerve paresthesia)

If you have had the above, please indicate the specific locations of the pain or numbness: _____

Have you seen a physician for these pains? ___Yes ___ No If yes, what is the name of the physician and when were you seen? _____

_____ Periodic breast pain and location: _____

Have you seen a physician for these pains? ___Yes ___ No If yes, what is the name of the physician and when were you seen? _____

Because insurance companies often want to know what conservative, non-surgical, treatments you have tried prior to considering surgery, please indicate which of the items below you have used in the past for the above symptoms:

_____ Physical therapy for back, neck, or shoulder pain in an outpatient physical therapy facility
Did this treatment provide you any relief from the symptoms? ___Yes ___Some ___None

_____ Physical therapy in the form of home exercises under the direction of a physician (please indicate the name of the physician: _____)
Did this treatment provide you any relief from the symptoms? ___Yes ___Some ___None

_____ Use of a support bra with weight-distributing straps
Did this treatment provide you any relief from the symptoms? ___Yes ___Some ___None

_____ Anti-inflammatory agents such as Tylenol or Ibuprofen, if you are medically able to do so
Did this treatment provide you any relief from the symptoms? ___Yes ___Some ___None

_____ Use of heat pads or cold compresses applied to areas of discomfort
Did this treatment provide you any relief from the symptoms? ___Yes ___Some ___None

_____ Use of appropriate local hygiene and topical medications for any skin irritations or rashes, including preventative such as powders or ointments
Did this treatment provide you any relief from the symptoms? ___Yes ___Some ___None

_____ Have you recently experienced a change in your weight? If so, has your weight increased or decreased, and by how much? _____

_____ Does discomfort or pain from your breasts affect your ability to perform certain types of exercises such as jogging? ___Yes ___No

When was your last mammogram? _____

What were the results of that mammogram? _____

If you have any other symptoms relating to your breast size which you feel is a factor in your decision to have surgery, please indicate below:

Printed Name

Signature

Date