Date _____

ATLANTA PLASTIC SURGERY, P.C.

Questionnaire for Breast Reduction Patients

CONFIDENTIAL INFORMATION: Information contained herein will not be released except when you have authorized us to do so. Please answer ***all*** questions to the best of your knowledge. The information that you provide will be used by your doctor in his/her decisions regarding your care.

Patient Information

Patient's Name _____ (Last / First / Middle) DOB ____ /____ /____ Age _____

Social Security No. _____-_____-_____

What size bra do you wear? _____ How long have your breasts been this size? _____years _____months

Do you have any of the following symptoms?

Neck Pain Yes ☐ No ☐ If yes, for how long? _____

Back Pain Yes ☐ No ☐ If yes, for how long? _____

Indention in shoulders from bra straps Yes ☐ No ☐ If yes, for how long? _____

Skin Irritation (Inframmary Crease) Yes ☐ No ☐ If yes, for how long? _____

Do have any discomfort or problems with your arms or legs? If so, please describe _____

_____

_____

Have you tried wearing different types of bras? Yes ☐ No ☐ If so, did they help relieve any of your discomfort?

_____

Does the size of your breasts interfere with any of your activities (running, walking, lifting, etc.) Yes ☐ No ☐ If so, please describe: _____

_____

Medication Information

Do you take any medication (over the counter or prescription) for your neck/back pain? If so, list name of medication, frequency and type of relief.

Medication	How often	Type of Relief
_____	_____	Poor ☐ Fair ☐ Good ☐ Other ☐ _____
_____	_____	Poor ☐ Fair ☐ Good ☐ Other ☐ _____
_____	_____	Poor ☐ Fair ☐ Good ☐ Other ☐ _____
_____	_____	Poor ☐ Fair ☐ Good ☐ Other ☐ _____
_____	_____	Poor ☐ Fair ☐ Good ☐ Other ☐ _____

Physician Information

Have you seen any other physicians for your neck/back discomfort? If so, please list and include advice given.

Name	Address	Recommendations
_____	_____	_____
_____	_____	_____
_____	_____	_____