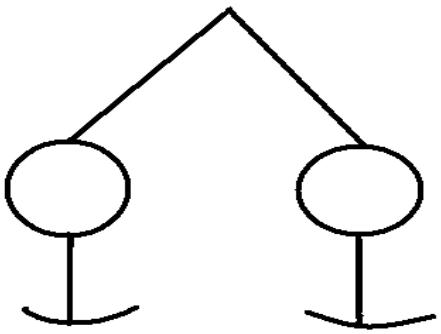
Wendy R.Gottlieb M.D., P.L.C.
Plastic and Reconstructive Surgery

Breast Reduction Questionnaire

Name:_____DOB_____
What are your symptoms related to your breasts? (Please check all that apply)
Height _____ Weight _____ Bra size _____

_____**Breast pain** _____**Lower back pain** _____**Rashes**
_____**Shoulder grooving** _____**Mid back pain** _____**Neck pain**
_____**Upper back pain** _____**Shoulder pain** _____**Headaches**
_____**Limitation of activity**
Other: _____
How long have you experienced these symptoms? _____
Have you had any previous treatment? _____
Have you seen you primary doctor for this problem? _____
Do you wear specialty/support bras? _____
How often you exercise? Type? _____
Have you taken any prescription drugs relating to you your symptoms? _____
Which prescriptions? _____
Did this help? _____ Complete relief / moderate relief/ minimal relief/ no relief
Have you taken any over the counter medications for this problem? _____
Which medications? _____
Did this help? _____ complete relief / moderate relief/minimal relief/ no relief _____
Have you seen a physical therapist? _____If so, was this helpful?_____
Have you seen a chiropractor? _____If so, was this helpful? _____
Number of Children: _____ ages: _____Did you breast feed? _____
Are you planning additional pregnancies? _____
Have you seen anyone else for this problem? _____
Any family history of breast cancer or breast disease? _____
Have you had any breast lumps, masses or cysts? _____
Have you have had breast cancer? _____
When was your last mammogram? _____ Was it normal? _____

(Below is for office use only)



____Masses/LAD _____BSA Calculated

____Skin Tone _____Schnur

____Ptosis Grade I/II/III

____Asymmetry

____Inframammary skin

____Grooving

_____Lateral Chest wall

Estimated grams of tissue to be removed: Right _____ Left _____

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