Aestique® Plastic Surgical Associates, Ltd.
Breast Reduction Questionnaire

Name_____ Birth date _____ Date _____

Height _____ Weight _____ Bra Size _____ Primary Doctor _____

Number of births _____ Breast Feed? Y/N Planning More Children? Y/N
Last Mammogram Date _____ Result _____
Previous Breast Surgery _____

Do you have any of the following: (Please Check all that apply)

_____Breast pain
_____Shoulder pain
_____Neck pain
_____Upper Back pain
_____Lower Back pain
_____Intertrigo
_____Poor Posture
_____Interferes with Daily Activity
_____Finger or Hand numbness
_____Bra strap indent/shoulder grooving
_____Ptosis Breasts
_____Nipple Discharge
_____Fibrocystic breasts
_____Breast Masses
_____Rash beneath breasts

Length of time symptoms experienced _____Please estimate the number of physician visits you sought over the past 5 years regarding these symptoms _____.
Please list the physicians by name and specialty from which you have sought treatment for these symptoms over the past 5 years.

Name	Specialty
_____	_____
_____	_____

Please list prescription medications taken for these symptoms over the past 5 years:
_____

Please list over the counter (non-prescription) medications used for these symptoms and the frequency of use over the past 5 years:
_____

Please check any of the medical or non-medical treatments or services below that you have used for your symptoms:

_____Physical Therapy If so, duration of treatment _____
_____Chiropractic If so, duration of treatment _____
_____Massage or ultrasonic treatment
_____Acupuncture
_____Support Bras
_____Spinal x-rays (neck or back)
_____Cold/ice
_____Electric Stimulation
_____Posture Training
_____Strengthening Exercises
_____Medications
_____Heat Therapy

Please list any other treatments or services used _____
_____

_____ _____
Signature Date