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BREAST REDUCTION QUESTIONNAIRE

Patient Name: _____ Date of Birth _____

Insurance Company _____ Policy Number _____

Current Height _____ Current Weight _____

Current Medications/why taken _____

Have you used NSAIDS(aspirin, ibuprofen, Aleve, Motrin) _____ How Long? _____

Has this provided relief ____ Yes ____ No

Have you had any weight loss or gain during the past six months ____ Yes ____ No

If so, how much _____ Was there any change in breast size ____ Yes ____ No

In the past five years, what was your maximum weight _____ Minimum Weight _____

What was your bra size when you weighed the least _____

Do you have grooves in the shoulders ____ Yes ____ No

Is this associated with redness or pain ____ Yes ____ No

Have you tried hot and/or cold therapy for back, shoulder, and neck pain ____ Yes ____ No

Has this provided relief ____ Yes ____ No How long have you tried this? _____

Do you have difficulty obtaining support with a bra ____ Yes ____ No / Current bra size ____

Has the support bra given you relief ____ Yes ____ No

How long have you worn a support bra? _____

Do you suffer from rash beneath the breasts ____ Yes ____ No/How often? _____

How is this treated _____ How Long? _____

Have you sought treatment for this condition ____ Yes ____ No

Have you experienced numbness or tingling in the fingers ____ Yes ____ No

Have you given birth or been pregnant within the past six months ____ Yes ____ No

Are you able to exercise regularly ____ Yes ____ No

Due to breast size, are your activities limited ____ Yes ____ No

If yes, explain _____

Due to breast size, do you experience difficulty at your job ____ Yes ____ No

If yes, please explain _____

Have you sought treatment from any of the following regarding pain/discomfort? If yes, give approximate dates and state whether treatment helped alleviate any symptoms.

Orthopedist _____ How long? _____

Physical Therapy _____ How long? _____

Chiropractic _____ How long? _____

Massage therapy _____ How long? _____

Dermatologist _____

Have any x-rays been taken ____ Yes ____ No

If yes, what were the results _____

Please list any other information which further explains your reasons for seeking breast reduction surgery at this time _____

Patient Signature

Date