



## 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 \_\_\_\_\_ (Preferably 2 years for insurance) Result \_\_\_\_\_

Previous Breast Surgery \_\_\_\_\_

Smoking Status \_\_\_\_\_ (If current smoker, pt must be enrolled in smoking cessation program for UPMC insurance)

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

- |   |   |
|---|---|
| <input type="checkbox"/> Breast pain                    | <input type="checkbox"/> Finger or Hand numbness            |
| <input type="checkbox"/> Shoulder pain                  | <input type="checkbox"/> Bra strap indent/shoulder grooving |
| <input type="checkbox"/> Neck pain                      | <input type="checkbox"/> Ptosis Breasts                     |
| <input type="checkbox"/> Upper Back pain                | <input type="checkbox"/> Nipple Discharge                   |
| <input type="checkbox"/> Lower Back pain                | <input type="checkbox"/> Fibrocystic breasts                |
| <input type="checkbox"/> Intertrigo                     | <input type="checkbox"/> Breast Masses                      |
| <input type="checkbox"/> Poor Posture                   | <input type="checkbox"/> Rash beneath breasts               |
| <input type="checkbox"/> Interferes with Daily Activity |   |

Length of time symptoms experienced \_\_\_\_\_ Please estimate the number of physician visits you sought over the past 5 years regarding these symptoms \_\_\_\_\_ (Must be 3 months of evaluation for UPMC insurance)

Please list the physicians by name and specialty from which you have sought treatment for these symptoms over the past 5 years.

<u>Name</u>	<u>Specialty</u>
_____	_____
_____	_____

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:

- |  |  |
|--|--|
| <input type="checkbox"/> Physical Therapy If so, duration of treatment _____ |  |
| <input type="checkbox"/> Chiropractic If so, duration of treatment _____     |  |
| <input type="checkbox"/> Massage or ultrasonic treatment                     | <input type="checkbox"/> Electric Stimulation    |
| <input type="checkbox"/> Acupuncture   | <input type="checkbox"/> Posture Training        |
| <input type="checkbox"/> Support Bras  | <input type="checkbox"/> Strengthening Exercises |
| <input type="checkbox"/> Spinal x-rays (neck or back)                        | <input type="checkbox"/> Medications             |
| <input type="checkbox"/> Cold/ice  | <input type="checkbox"/> Heat Therapy            |

Please list any other treatments or services used \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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