BELLISSIMO PLASTIC SURGERY
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
_____Unspecified 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 (Duration of treatment: _____)
_____Chiropractic (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

Please list any other treatments or services used _____

_____

_____ _____

Signature **Date**

Revised: 7/1/15