BREAST REDUCTION EVALUATION – TO BE COMPLETED BY PATIENT

PATIENT NAME:____ DATE:____________________

1. Have you had a mammogram? ____________________
   Approximate date: ______________________________
   Facility where mammogram performed:____

2. Have you been treated by an Orthopedic Surgeon for evaluation of back/ shoulder/ neck pain ? _______________
   Name of Physician: ____
   Duration of treatment: ____

3. Have you been treated by a Chiropractor? ___________________
   Name of Physician:____
   Duration of treatment:____

4. Have you undergone physical therapy? ___________________
   Duration of treatment:____

5. Have you been prescribed non steroidal anti-inflammatory drugs (NSAIDS) and /or muscle relaxant medications?____________________
   If so please list: ____
   ____
   ____
   Duration of treatment:____

6. Have you taken over the counter non- steroidal anti-inflammatory drugs (NSAIDS)? ______
   If so please list: ____
   ____
   ____
   Duration of treatment:____

7. Do you have symptoms of skin breakdown under the breasts?____________________
   If so please specify:____
   Have you been treated by a Dermatologist for this condition: __________________

8. Please list limitations of daily living activities directly related to large breasts :
   ____
   ____
   ____
   ____
   ____

TO BE COMPLETED BY OFFICE STAFF

Patient Height:_____________ Patient Weight:_____________ Patient Bra Size: ____________

Approximate Grams to be removed: _____________Right _____________ Left