HOWARD J. PEROFSKY, M.D.
BREAST REDUCTION QUESTIONNAIRE

NAME: _____ DATE: _____

Please answer the following questions.

SYMPTOMS: (Please check **all** that apply)
( ) Back pain ( ) Shoulder pain ( ) Shoulder grooving
( ) Neck pain ( ) Rash under breast

1. How long have you had the above symptoms (please be specific in months or years) ? _____
2. Have you ever taken **ANY** medications for the above symptoms ? ( ) Yes ( )No If yes, what medications? _____
3. Have you ever received treatment, including prescribed medications, from another physician, chiropractor or physical therapist for the above symptoms ?
   ( ) Yes ( ) No
   If so, what type of treatment have you received and for what length of time did this treatment continue (please be specific and provide documentation at initial visit if available) ?
   _____
   _____
   _____
4. Current Bra size _____
   Have you used specialty bras or support garments to help support the weight of your breasts ?
   _____
5. Height _____ Current Weight _____
6. Have you had a mammogram? ( ) Yes ( ) No
   If yes, where? _____ when?_____ result?_____
   Please provide a copy of the mammogram report (not films) at your initial visit if mammogram was done within the past year.
7. How many children do you have ? _____ What are their ages ? _____
   Did you breast-feed your children ? ( ) Yes ( ) No
   Although some women have been able to breast-feed after breast reduction surgery, in general, this is not predictable. Would this influence your decision to have this surgery? ( ) Yes ( ) No
8. Have you attempted weight loss in the **past year** ? ( ) Yes ( ) No
   If yes, how much did you lose ? _____ Did it affect your breast size any ? ( ) Yes ( ) No
   Have you ever been on a supervised weight loss program and/or on weight reduction medications prescribed by a physician ? ( ) Yes ( ) No
   If so, where, when and what were the results of the program (please be specific and provide documentation at initial visit if available) ?
   _____
   _____
9. Have you ever had surgery on your breasts ? ( ) Yes ( ) No
   If yes, where?_____ when?_____
10. Any family history of breast cancer ? ( ) Yes ( ) No
    If yes, what relation? _____
11. What is your occupation ? _____
    What affect, if any, does your breast size have on your performance of job duties ?
    _____
    _____