ROBERT J. SPIES, MD, PC
Aesthetic and Reconstructive Plastic Surgery

BREAST REDUCTION QUESTIONNAIRE

(Please complete all item. Please print)

Name:_____Date:_____

1. At what age did you first begin to note rapid breast enlargement?_____

2. Has you body weight been stable within +/- 10 lbs., during the past year?
☐Yes ☐ No
3. Are your breasts presently at the largest size they have ever been?
☐Yes ☐No (If no, at what age were your breasts the largest?)____
4. Have you experienced any chronic or recurrent back pain or discomfort?
☐Yes ☐ No
5. Have you had any chronic or recurrent neck pain or discomfort?
☐Yes ☐ No
6. Has any physician told you that your back or neck strain is directly related to your large breasts?
☐Yes (Please give name_____ ☐NO
7. Do you have any function limitations in daily activities because of your large breasts?
☐No ☐Yes (Please explain)

_____

_____

_____

8. Because of your large breast, do you have any inability to exercise properly?
☐No ☐Yes (Please explain)

_____

_____

9. Have you had any problems with recurrent headaches? ☐ Yes ☐ No
If yes, have you been told by a neurologist or other physician that the headaches may be caused by your large breasts? ☐No ☐Yes (Name of physician _____)
10. Do you have shoulder pain where the bra strap crosses the shoulder?_____
11. Do you have furrow (depressions) in the shoulder region where you bra strap crosses the shoulder?_____
12. Do you have the constant sensation of a heavy anterior chest wall and uncomfortable breasts? _____
13. Have you noted numbness of the little finger of your hand?_____
14. Have you experienced any pain radiating down the arm to the elbow region?
☐Yes ☐No