INSTITUTE OF PLASTIC SURGERY

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BREAST REDUCTION INFORMATION

Last Name	First Name	Middle	Today's Date

Current Bra Size:	Desired Bra Size:

Do you smoke? ☐ No ☐ Yes If so, how many packs per day: _____ How many years: _____

Are you experiencing any of the following problems? (Check all that apply)

☐ Headache	☐ Breast Pain	☐ Neck Pain	☐ Shoulder Pain
☐ Back Pain	☐ Numbness / Tingling of Hands	☐ Rashes under breasts	☐ Bra strap indentation

Are you taking any medications for these symptoms? ☐ **No** ☐ **Yes**

Please list the medications:

In your own words, please describe how your symptoms affect your daily functioning:

Have you tried any of the following therapies to help with your symptoms:

Chiropractic	**From:**	**To:**	**Facility:**
Massage Therapy	**From:**	**To:**	**Facility:**
Physical Therapy	**From:**	**To:**	**Facility:**

History of Breast Cancer

Have you ever had a mammogram? ☐ **No** ☐ **Yes**

If so, when was your most recent mammogram:

Date: _____

Facility: _____

Was the mammogram normal? ☐ **No** ☐ **Yes**

If abnormal, what was found? _____

History of Breast Cancer

Have you had breast cancer? ☐ **No** ☐ **Yes**

Any family members with breast cancer? ☐ **No** ☐ **Yes**

If so, please list which relative(s):

Relationship: _____

Relationship: _____

Relationship: _____

Relationship: _____

FOR OFFICE USE ONLY BELOW THIS LINE

Measurements	Right	Left
SN-N		
N-IMF		
Estimate of Grams		

Height	
Weight	