**KDS Aesthetics**
**Breast Reduction Questionnaire**

Name: _____ DOB: _____ Chart#:_____

What bra size do you wear: _____ How long have your breasts been this size? _____ years _____ months

Do you have any of the following symptoms?

| | | | |
|---|---|---|---|
| Back Pain | ☒ YES | ☒ NO | If yes, how long? _____ years _____ months |
| Neck Pain | ☒ YES | ☒ NO | If yes, how long? _____ years _____ months |
| Shoulder Indentations | ☒ YES | ☒ NO | If yes, how long? _____ years _____ months |
| Skin Irritation Beneath Breasts | ☒ YES | ☒ NO | If yes, how long? _____ years _____ months |

Have you been treated by a healthcare professional for any of these issues? ☒ YES ☒ NO If yes, please describe and include the any provider's name, estimated date of care, and recommendations given: _____

_____

_____

Do you take any over the counter or prescription medications for your neck, back, or shoulder pain, or to treat skin infections beneath the breasts? ☒ YES ☒ NO If yes, please list the name of medication, frequency, and type of relief below:

| Medication | How Often | Type of Relief | When did you start taking? |
|---|---|---|---|
| _____ | _____ | ☒ Poor ☒ Fair ☒ Good ☒ Other | _____ |
| _____ | _____ | ☒ Poor ☒ Fair ☒ Good ☒ Other | _____ |
| _____ | _____ | ☒ Poor ☒ Fair ☒ Good ☒ Other | _____ |
| _____ | _____ | ☒ Poor ☒ Fair ☒ Good ☒ Other | _____ |

Have you attempted weight loss? ☒ YES ☒ NO If so, please describe the method and impact on pain: _____

_____

_____

Do you have any discomfort in your arms or legs? If so, please describe: _____

_____

Have you tried wearing different types of bras? ☒ YES ☒ NO If so, did they help relieve any of your discomfort?

_____

Does the size of your breasts interfere with any activities (running, walking, lifting, etc.) ☒ YES ☒ NO

If so, please describe: _____

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