

Albear Plastic Surgery

BREAST REDUCTION PATIENT QUESTIONNAIRE

Name (Please Print): _____

Height: _____ feet _____ inches Weight: _____ lbs Bra Size: _____

Please list the symptoms you have had that you feel are related to your breast size and what alternative medical treatment (e.g. medication, exercise, heat/cold, etc.) has been tried **unsuccessfully** to relieve the symptoms. You must provide documentation from all treating physicians (e.g. orthopedic surgeon, primary care physician, chiropractor, etc) as backup for the symptoms and treatment you list.

SYMPTOM	TREATMENT	DATES	DOCTOR (Incl specialty)

Explain how the above symptoms interfere with your ability to function normally:

Signature _____

Date _____