QUESTIONNAIRE FOR WOMEN CONSIDERING BREAST REDUCTION SURGERY

1. Do you feel your breasts are: too big or too small or just right?
   (Circle One)

2. If you picked "too big" above, do you feel that your breasts sometimes get in the way of your normal activities. Yes ____ No ____

3. Do your breasts hurt frequently or constantly or just during menses, or not at all?
   (Circle One)

4. Do you have grooving or scars on your shoulders as a result of excessive pressure on your shoulders by your bra strap? Yes ___ No ___

5. Have you experienced irritation (rash or intertrigo) of the skin underneath your breasts, perhaps during the summer months of the year? Yes ___ No ___

6. Do you have neck pain that you believe is related to the large size of your breasts?
   Yes ___ No ___

7. Do you have upper back pain or shoulder pain that you believe is related to the large size of your breasts? Yes ____ No ____

8. What is your present bra size? ____________

9. Is this a comfortable bra fit or a little too loose or a little too tight?
   (Circle One)

10. Have you ever taken or been prescribed anti-inflammatory medicines (NSAID) such as Ibuprofen for the discomfort related to your large breasts? Yes ___ No ___

11. Have you ever taken or been prescribed occupational or physical therapy for the discomfort related to your large breasts? Yes __ No __

12. Have you ever used special support bras? Yes ___ No ___

13. Is there anyone in your family who has been diagnosed with breast cancer?Yes __ No__
    If yes, be sure to discuss this with your physician.

14. Have you ever had a mammogram? Yes ___ No__
    If yes, what was the date of your last mammogram (month and year) ____________

15. Do you know anyone who has had a breast reduction operation? Yes ____ No___
    Whom? ________________________

Signature ___________________ Date _____________