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PROFILE FOR BREAST REDUCTION PATIENTS

Patient Name: ______________________________ Date of Birth: ____________

Height: __________ Weight: ___________

Number of Children: _________ Age of Youngest? _______________________

Are you pregnant? Y / N Which method of birth control are you using?

____

Date of last breast exam? ____

Date of last mammogram? _________________ Which facility and phone number?____

Do you have a personal or a family history of breast cancer? Y / N
If yes, which family member?____

Bra Size:____

Which symptoms are you experiencing:

Breast Pain:	YES	NO
Neck Pain:	YES	NO
Back Pain:	YES	NO
Shoulder Pain:	YES	NO
Shoulder Grooving:	YES	NO
Hand Numbness:	YES	NO
Headaches:	YES	NO
Rashes/Infections beneath breasts:	YES	NO

How long have you had the above symptoms?________________________