BREAST REDUCTION WORKSHEET

PATIENT DATA

Name:_____ Date:_____
Age:_____ Height:_____ Current Weight:_____ Goal Weight:_____
Weight Fluctuations:_____
Marital Status (Married/Single/Etc)?_____

Number of Pregnancies:_____ Number of births:_____ Number of times breastfed:_____
Are You Planning To Have Future Pregnancies? Yes No
Are You Planning To Breastfeed? Yes No

Are You Post-Menopausal? Yes No

BREAST SYMPTOMS – check all that apply

☐ Back Pain ☐ Difficulty with Clothing ☐ Headaches
☐ Neck Pain ☐ Difficulty with Posture ☐ Shoulder Grooving
☐ Breast Pain ☐ Difficulty with Exercising ☐ Skin Irritation/Intertrigo/Rashes
☐ Nipple Bleeding ☐ Nipple Discharge
☐ Nerve Compression Symptoms (for example, tingling, numbness in hands)
☐ Other: _____

ONCOLOGIC/BREAST INFORMATION

Breast Cancer? Yes (Family) (Personal) No
History of Other Cancers:_____
Prior Breast Surgeries?_____
Prior Breast Biopsies or Masses?_____
Latest Mammogram?_____ Any Mammogram Abnormalities?_____

EXPECTATIONS:

Current Size/Bra:_____
Desired Size/Bra:_____
Are there any asymmetries between your breasts? _____
What are your goals for your breast surgery?_____
Is there anything you wish to avoid with your breast surgery?_____

PLEASE LIST ANYTHING ELSE YOU WOULD LIKE US TO KNOW:

_____
_____
_____
_____
_____
_____