Breast Reduction Patient Questionnaire

Patient Name: ___________________________ Date of Visit: _______________________

Part A: The questions in this section (pages 1-2) ask you about your health.

1. In general, would you say your health is: (Circle one number)

   - Excellent……….  1
   - Very Good…….  2
   - Good…………..  3
   - Fair………….….  4
   - Poor…………….  5

2. Compared to one year ago, how would you rate your health in general now? (Circle one number)

   - Much better now than one year ago………..  1
   - Somewhat better now than one year ago….  2
   - About the same…………………………….  3
   - Somewhat worse now than one year ago…..  4
   - Much worse now than one year ago……….  5

The following items are about activities you might do during a typical day. Does your health limit you in these activities? If so, how much?

3. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports…………………………………………….     1    2    3
4. Moderate activities, such as moving a table, pushing vacuum cleaner, bowling, or playing golf………………………………….     1    2    3
5. Lifting or carrying groceries ……………………………………………….     1    2    3
6. Climbing several flights of stairs ……………………………………………….     1    2    3
7. Climbing one flight of stairs ……………………………………………….     1    2    3
8. Bending, kneeling, or stooping ……………………………………………….     1    2    3
9. Walking more than a mile …………………………………………………     1    2    3
10. Walking several blocks…………………………………………………….     1    2    3
11. Walking one block………………………………………………………….     1    2    3
12. Bathing or dressing yourself……………………………………………….     1    2    3

During the past 4 weeks, have you had any of the following problems with your work or other regular activities as a result of your physical health? (Circle one number on each line)

   - Yes, Limited a Lot
   - Yes, Limited a Little
   - No, Not Limited at All

13. Cut down the amount of time you spent on work or other activities………..    1   2
14. Accomplished less than you would like ………………………………….....    1   2
15. Were limited in the kind of work or other activities ………………………..    1   2
16. Had difficulty performing the work or other activities (for example, it took extra effort)…………………………………………...    1   2

During the past 4 weeks, have you had any of the following problems with your work or other regular activities as a result of any emotional problems (such as feeling depressed or anxious)? (Circle one number on each line)

   - Yes
   - No

17. Cut down the amount of time you spent on work or other activities………..    1   2
18. Accomplished less than you would like ………………………………….....    1   2
19. Didn’t do work or other activities as carefully as usual…………………….    1   2
20. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? (Circle one number)
   - Not at all ……  1
   - Slightly ……  2
   - Moderately ……  3
   - Quite a bit ……  4
   - Extremely ……  5

21. How much bodily pain have you had during the past 4 weeks? (Circle one number)
   - None ……  1
   - Very mild ……  2
   - Mild ……  3
   - Moderate ……  4
   - Severe ……  5
   - Very severe ……  6

22. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? (Circle one number)
   - Not at all ……  1
   - A little bit ……  2
   - Moderately ……  3
   - Quite a bit ……  4
   - Extremely ……  5

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

<table>
<thead>
<tr>
<th>How much of the time during the past 4 weeks . . .</th>
<th>(Circle one number on each line)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Of the Time</td>
<td>Most of the Time</td>
</tr>
<tr>
<td>23. Did you feel full of pep? …………………..</td>
<td>1</td>
</tr>
<tr>
<td>24. Have you been a very nervous person? ………</td>
<td>1</td>
</tr>
<tr>
<td>25. Have you felt so down in the dumps that nothing could cheer you up? …………………..</td>
<td>1</td>
</tr>
<tr>
<td>26. Have you felt calm and peaceful? …………..</td>
<td>1</td>
</tr>
<tr>
<td>27. Did you have a lot of energy? ……………….</td>
<td>1</td>
</tr>
<tr>
<td>28. Have you felt downhearted and blue? ………..</td>
<td>1</td>
</tr>
<tr>
<td>29. Did you feel worn out? ………………………</td>
<td>1</td>
</tr>
<tr>
<td>30. Have you been a happy person? ……………….</td>
<td>1</td>
</tr>
<tr>
<td>31. Did you feel tired? ………………………..</td>
<td>1</td>
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</tbody>
</table>

32. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)? (Circle one number)
   - All the time ……  1
   - Most of the time ……  2
   - Some of the time ……  3
   - A little of the time ……  4
   - None of the time ……  5

How true or false is each of the following statements for you? (Circle one number on each line)

<table>
<thead>
<tr>
<th>How true or false is each of the following statements for you?</th>
<th>Definitely True</th>
<th>Mostly True</th>
<th>Don’t Know</th>
<th>Mostly False</th>
<th>Definitely False</th>
</tr>
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<tbody>
<tr>
<td>33. I seem to get sick a little easier than other people…</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>34. I am as healthy as anybody I know ……</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td>35. I expect my health to get worse ……</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td>36. My health is excellent ……</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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Part B: The questions in this section (pages 3-4) ask about Specific Symptoms

Patient Name: _______________________________ Date of Visit: __________________

Please list the following: Height: ________________  Weight: ________________
Brassiere Size: _________  Please estimate the breast size you would like to obtain. _________
Recent change in weight over previous year: ________________

Please answer the following questions:

Have you ever had a mammogram? __________  If yes, please list the location and date:
______________________________________________________________

Are you planning to have children in the future? ____________________________
Are you planning to breast feed in the future? ____________________________
Do you have plans to lose weight in the future? ____________________________

Please check any of the symptoms below that apply to you:

_____ Large breasts
_____ Breast lump
_____ Breast/nipple discharge
_____ History of breast cancer
_____ Family member with breast cancer
_____ Neck pain
_____ Back pain
_____ Breast pain
_____ Chest pain
_____ Shoulder pain
_____ Poor sensation/feeling in nipples
_____ Poor posture
_____ Decreased physical activity related to breasts
_____ Inability to participate in exercise or sports due to breasts
_____ Bra straps causing grooves in skin and skin changes
_____ Skin problems around breasts
_____ Skin rash around breasts
_____ Acne/pimples around breasts
_____ Low self-esteem due to breasts
_____ Psychological problems due to breasts
_____ Embarrassing comments from others
_____ Difficulty finding clothing that fits
_____ Difficulty sleeping comfortably
_____ Headache
_____ Hand Numbness
_____ Fatigue

Estimate the duration of the above symptoms ____________________________________________
Please estimate the number of physician visits you sought over the past 5 years regarding these symptoms __________. Please list the physicians by name and specialty from which you have sought treatment for these symptoms over the past 5 years.

<table>
<thead>
<tr>
<th>Name</th>
<th>Specialty</th>
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Please list prescription medications taken for these symptoms over the past 5 years. __________

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Please list over the counter (non-prescription) medications used for these symptoms and the frequency of use over the past 5 years. ________________________________

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Please estimate the hours of work lost due to the above symptoms over the past year_________

List your type of employment ________________________________

Please check any of the medical or non-medical treatments or services below that you have used for your symptoms:

______ Physical Therapy
______ Chiropractic
______ Acupuncture
______ Special Bras
______ Back braces/special supports
______ Spinal X-rays (Neck or back)
______ Psychotherapy
______ Heat
______ Cold/ice
______ Hydrotherapy
______ Massage or ultrasonic treatment
______ Electric Stimulation
______ Injections
______ Posture training
______ Relaxation
______ Biofeedback
______ Stretching exercises
______ Strengthening exercises
______ Medications

Please list any other treatments or services used. ______________________________________

____________________________________________________________________________
Part C: These questions assess concerns about your physical appearance. Please read each question carefully and circle the answer that best describes your experience. Also write in answers where indicated.

1. Are you very concerned about the appearance of your breasts. (Do you feel that they are especially unattractive or ugly)  
   Yes No

   1a. If yes: Does this worry you? That is, do you think about this a lot and wish you could think about it less?  
      Yes No

   1b. If yes: What specifically bothers you about the appearance of your breasts? Explain in detail: ________________________________

2. Has the appearance of your breasts caused you a lot of distress, torment or pain?  
   Yes No

3. Has the appearance of your breasts interfered with your social life?  
   If yes: How? ________________________________
   ________________________________
   ________________________________

4. Has the appearance of your breasts significantly interfered with your functioning in your job or work at home?  
   If yes: How? ________________________________
   ________________________________
   ________________________________

   Are there things you avoid because of your breasts?  
   If yes: What are they? ________________________________
   ________________________________
   ________________________________

5. Have the lives or normal routines of your family or friends been affected by your preoccupation with your breasts.  
   Yes No

6. How much time do you spend thinking about your breasts per day on average? (Circle one)  
   a. Less than 1 hour a day  
   b. 1-3 hours a day  
   c. More than 3 hours a day

Signature of Patient __________________________ Date ______________