PLASTIC SURGERY CONSULTANTS
Cosmetic & Reconstructive Surgery of the Head, Neck, Breast,Trunk & Extremities
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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? **(Circle one number on each line)**

	Yes, Limited A Lot	Yes, Limited a Little	No, Not Limited at All
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	No
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.

How much of the time during the past 4 weeks . . .	**(Circle one number on each line)**					
	All Of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
23. Did you feel full of pep? ……..	1	2	3	4	5	6
24. Have you been a very nervous person? ……..	1	2	3	4	5	6
25. Have you felt so down in the dumps that nothing could cheer you up? ……..	1	2	3	4	5	6
26. Have you felt calm and peaceful?…… ……..	1	2	3	4	5	6
27. Did you have a lot of energy? ……..……..	1	2	3	4	5	6
28. Have you felt downhearted and blue? .. ……..	1	2	3	4	5	6
29. Did you feel worn out? ……..	1	2	3	4	5	6
30. Have you been a happy person? ……..……..	1	2	3	4	5	6
31. Did you feel tired? ……..……..	1	2	3	4	5	6

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)**				
	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
33. I seem to get sick a little easier than other people…	1	2	3	4	5
34. I am as healthy as anybody I know ……..…	1	2	3	4	5
35. I expect my health to get worse ……..…..…	1	2	3	4	5
36. My health is excellent ……..…	1	2	3	4	5

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.

Name	Specialty
_____	_____
_____	_____
_____	_____
_____	_____

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? **Yes** **No**
   If yes: How? _____
   _____
   _____

4. Has the appearance of your breasts significantly interfered with your functioning in your job or work at home? **Yes** **No**
   If yes: How? _____
   _____
   _____

   Are there things you avoid because of your breasts? **Yes** **No**
   If yes: What are they? _____
   _____
   _____

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

7. 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 _____