

BREAST REDUCTION EVALUATION SHEET

Welcome to Columbus Aesthetic and Plastic Surgery. Please share the following information with us, so that we can better serve you.

Name: _____

Appointment date: _____

Age: _____

Height: _____

Weight: _____

Recent weight loss? Y/N

If yes, how much? _____

Have you been referred here by another physician? Y/N

If yes, has your physician sent documentation? Y/N

Current bra size: _____

Bra size you would like to be: _____

Date of last mammogram: _____

Mammogram normal? Y/N

Do you have a family history of breast cancer? Y/N

Ovarian Cancer? Y/N

Do you have a personal history of breast problems? Y/N

If yes, explain: _____

Do you have any of the following symptoms? (please check all that apply)

Neck Pain

Shoulder Pain

Upper/Mid Back Pain

Low Back Pain

Skin rashes or infections on or under your breasts

Shoulder Grooving

Headaches

Other _____

How long have you had the above symptoms? _____

Have you done any of the following to treat your symptoms? (please check all that apply)

Ibuprofen/Advil/Motrin/Aleve

Powders and/or creams

Prescription antibiotics (for skin infections)

Massage therapy

Support garments (e.g, changed bras, larger bra straps, etc.)

Chiropractics

Cold/Heat therapy

Physical therapy or exercises

How long have you been trying these remedies? _____

Do you smoke? Y/N

If yes, how much? _____

If you recently quit, how long ago? _____

**Please note that smoking substantially increases your risk of wound healing complications after surgery*

**If you smoke you need to quit smoking and all nicotine containing quitting aids (gum, the patch, etc.) completely for at least three weeks before surgery and three weeks after surgery.*

**You should also not be around secondhand smoke for the three weeks before and after surgery, as this can also increase your risk of complications.*