

Breast Reduction Questionnaire
(Patient's personal letter of medical necessity)

Have you ever been diagnosed with or experienced any of the following:

- | | |
|---|--|
| <input type="checkbox"/> Breast cancer | <input type="checkbox"/> Breast Biopsy |
| <input type="checkbox"/> Fibrocystic breast disease | <input type="checkbox"/> Trauma/injury to breast |

Please indicate which of the following symptoms you have experienced:

- | | |
|--|---|
| <input type="checkbox"/> Breast pain | <input type="checkbox"/> Arm/hand numbness/tingling |
| <input type="checkbox"/> Rashes beneath or between breasts | <input type="checkbox"/> Shoulder grooving from bra straps |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Upper back pain |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Difficulty with physical activities/exercise |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Other: _____ |

How long have you had the above symptoms? _____

Have you tried any of the following treatments for you symptoms:

- | | |
|--|-----------------|
| <input type="checkbox"/> Ointments/sprays for rashes | How long? _____ |
| <input type="checkbox"/> Heating pads/ice packs | How long? _____ |
| <input type="checkbox"/> Stretches/therapeutic exercises at home | How long? _____ |
| <input type="checkbox"/> Physical therapy | How long? _____ |
| <input type="checkbox"/> Chiropractic care | How long? _____ |
| <input type="checkbox"/> Supportive/wide strapped bras | How long? _____ |
| <input type="checkbox"/> Over-the-counter medications | How long? _____ |

List them: _____

- | | |
|---|-----------------|
| <input type="checkbox"/> Prescription medications | How long? _____ |
|---|-----------------|

List them: _____

Have you had any surgery to alleviate the above symptoms: YES / NO

List them: _____

In your own words, please describe the reasons you feel that breast reduction surgery is medically needed? (The psychological effects of having large breasts do not support the medical need for a surgery.)

Patient Name

Signature

Date

Please note, some insurance carriers will require documentation to support the necessity of surgery. It is the patient's responsibility to obtain documentation. We will notify you if any such documentation is needed.

How would you prefer we contact you if necessary? Email / Phone / Mail