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BREAST REDUCTION QUESTIONNAIRE

HAVE YOU EVER HAD ANY PROBLEMS WITH YOUR BREASTS (CYST, FIBROIDS, BIOPSIES ETC.) _____

IF YES, PLEASE EXPLAIN _____

HOW MANY PREGNANCIES HAVE YOU HAD? _____

HOW MANY CHILDREN DO YOU HAVE? _____

DID YOU BREAST FEED ANY OF YOUR CHILDREN? _____

DO YOU PLAN TO HAVE ANY CHILDREN IN THE FUTURE? _____

IS THERE A HISTORY OF BREAST CANCER IN YOUR FAMILY? _____

IF SO WHOM? _____

HEIGHT _____

WEIGHT _____

BRA SIZE _____

HAVE YOU EVER HAD A MAMMOGRAM? YES NO
IF YES, WHEN _____ WHERE _____

RESULTS _____

WHAT KIND OF DISCOMFORT DO YOU HAVE WITH YOUR BREAST?

DO YOU GET A RASH UNDER YOUR BREASTS? _____

HAVE YOU EVER BEEN TREATED FOR BACK PAIN RELATED TO BREAST SIZE?
_____ IF YES BY WHOM, _____

WHAT TYPE OF TREATMENT _____

ANY MEDICATIONS GIVEN? IF SO NAME OF MEDICATION _____

DOES YOUR BREAST SIZE CHANGE WITH WEIGHT GAIN OR LOSS? _____