

KENNETH L. ODINET, DDS, MD

PLASTIC AND RECONSTRUCTIVE SURGERY

200 Beaulieu Drive, Building 6

Lafayette, LA 70508

Phone: (337) 234-8648

Fax: (337)233-0244

Confidential Health Questionnaire for Breast Reduction

Name: _____ Chart #: _____

Patient Current Bra Size: _____ Desired Bra Size: _____

- Have you had a mammogram? **Yes No**

If yes, please give date and results: _____

What facility was your mammogram done? _____

- Have you had a physician examine your breasts? **Yes No**

If yes, please give date and results: _____

- Do you perform a regular breast self exam? **Yes No**

If yes, have you found any abnormalities? _____

- Have you had any problems with your breast? **Yes No**

If yes, please give date and details: _____

- Has anyone in your family had breast problems? **Yes No**

If yes, please give details: _____

- Which of the following problems do you have that may be related to your breasts?

Back Pain **Neck Pain** **Shoulder Pain** **Breast Pain** **Rashes Under Breast**

Poor Posture **Headaches** **Hand Numbness** **Grooves in Shoulders from Bra**

- What have you tried to make these problems better?

Medications **Physical Therapy** **Weight Loss** **Special Bras** **Chiropractic Treatment**

Result after trying the indicated methods? _____

In what way does your breast size interfere with physical activities or normal daily activities? _____

- Have you had any work loss due to excessive breast size? **Yes No**

If yes, please give details: _____

Confidential Health Questionnaire for Breast Reduction: **Physician**

Physical Exam:

Height: _____ Weight: _____ lbs BMI: _____ Temp: _____ BP: _____ Pulse: _____

Breasts:

	R	L		R	L
Masses			Notch to Nipple		
Discharge			Nipple to IMF		
Skin Tone			Base Width		
Ptosis					
Grooves					

HEENT: _____

Cardio: _____

Respiratory: _____

GI: _____

GU: _____

Neuro: _____

Other: _____

Estimated amount of tissue to be removed _____ g per breast.

Post-Op Bra Size: _____

Impression:

Probability of improving function and relieving the clinical signs of symptomatic breast hypertrophy: _____

_____.

*I have read and reviewed all questions and answered to the fullest of my knowledge.

Signature: _____ Date: _____