LOHNER PLASTIC SURGERY

Ronald A. Lohner, M.D.

Patient Name:____ Date:________________

REDUCTION MAMMAPLASTY QUESTIOINNAIRE

Please check any/all of your symptoms of breast enlargement:

□ Back Pain □ Pain in Upper Back □ Neck Pain □ Breast Pain □ Pain in Shoulders
□ Shoulder Grooving □ Pain/Discomfort/Ulceration from Bra Straps in Shoulders
□ Rashes Beneath Breasts □ Kyphosis (Documented by X-Ray) □ Hand Numbness

Have you had treatment for the above symptoms: YES NO

If yes, have you had:

□ Failed Physical Therapy □ Failed Rx Medications □ Failed Alternative Therapy

Explain including treatment, durations and medications:

____

____

____

Do you have documentation of failed conservative treatment: YES NO

Height______________ Weight______________ Bra Size______________ Age__________

Did you breast feed? YES NO NOT APPLICABLE

Could you breast feed? YES NO NOT APPLICABLE

Did your breast size change significantly with pregnancy and/or breast feeding?

YES NO NOT APPLICABLE If yes, specific cup sizes: ____________________________

Do you plan on having children/ more children? YES NO

Please list any history of breast surgery with date and reason: ____________________

____

Date and location of latest Mammogram:____

Family History of Breast Cancer/Breast Disease:___________________________________

____

919 Conestoga Road
Building One, Suite 200
Rosemont, PA 19010

610-519-0600 Phone
610-519-1238 Fax
www.lohnerplasticsurgery.com