

**LONGWOOD PLASTIC SURGERY, P.C.**  
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**BREAST REDUCTION CONSULTATION QUESTIONNAIRE  
PRE-DETERMINATION WORKSHEET**

(Please fill out this worksheet to the best of your knowledge so we can submit a letter to your insurance company to obtain prior authorization)

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_ PCP's NAME: \_\_\_\_\_

SS# \_\_\_\_\_ REASON FOR TODAY'S VISIT: \_\_\_\_\_

CURRENT BRA SIZE: \_\_\_\_\_ Do you have a family history of breast cancer? If so, who? \_\_\_\_\_

Have you recently had a mammogram? What was the result? \_\_\_\_\_

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**SYMPTOMS:**

How long have you suffered with this problem?

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Do you experience:

\_\_\_\_\_ Neck, shoulder or back pain? (If so, please specify duration)

\_\_\_\_\_ Shoulder grooving (indentations from bra straps)?

\_\_\_\_\_ Skin rashes (intertrigo) from skin rubbing on skin? If yes, where? \_\_\_\_\_

Medications used for rashes \_\_\_\_\_

Did medication help? \_\_\_\_\_ How long did you use the medication(s)? \_\_\_\_\_

Have you recently lost or gained weight? \_\_\_\_\_ Yes \_\_\_\_\_ No If so, how much and what affect did this have on your breast size? \_\_\_\_\_

Have you tried any non-surgical techniques to relieve or decrease your symptoms? (ie. Chiropractor, Physical Therapy, Medications) \_\_\_\_\_ Yes \_\_\_\_\_ No If so, what was the result of that visit or treatment? (Please specify) \_\_\_\_\_

\_\_\_\_\_

How has this condition affected your lifestyle? (Be specific)

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Does this problem affect your daily functioning and if so, how? (Be specific)

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