ADVANCED CONCEPTS
IN PLASTIC SURGERY

Breast Reduction Questionnaire

Name: _____Age: ___

Height: _____ Weight: _____

Listed below are common questions that insurance companies ask when they are determining whether a breast reduction would be considered medically necessary. Please provide sufficient information to each question below. This will help provide a more timely reply back from the insurance company. Just remember the more information you give us, the more information we can provide to the insurance company. This will help us try to get an approval for your breast reduction.

DO YOU HAVE	Shoulder Grooving	YES	NO
	Shoulder Pain	YES	NO
	Back Pain	YES	NO
	Neck Pain	YES	NO
	Breast Pain	YES	NO
	Skin Rashes	YES	NO
	Chronic Headaches	YES	NO
	Chest Wall Pain	YES	NO
	Ulnar Nerve Compression	YES	NO

Do you take any type of over-the-counter or prescribed medication to relieve any of the symptoms listed above? YES NO

Please list. _____ Does the medication help? YES NO

Does the medication help? YES NO

Have you seen a chiropractor YES NO or physical therapist? YES NO

If so, How Long? _____ Has it helped? _____

Have you tried different types of bras to offer more support? YES NO

If so, How Long? _____ Has it helped? _____

Have you tried any exercise or diet programs? YES NO

If so, How Long? _____ Has it helped? _____

Have you had a mammogram? YES NO

If so, when? _____ Where? _____
*If you are 40 or older, we will need to submit a copy of your most recent mammogram result with your preauthorization letter. Please bring this information with you.

Do you have any supporting letters or medical records from any physicians, therapists, or chiropractors that have treated you for the above symptoms? YES NO

Please list._____

I certify that the above information is correct.

Signature Date

PHYSICIAN ONLY

Current Breast Size: _____ Reduce to: _____

Amount of grams: _____ OR Time: _____