Breast Evaluation Questionnaire

Name:____ Age: ________

Bra Size:_________________ Height: _______________ Weight:___________

Do you have any of the following (yes or no):

Bra Strap Indentation	______________________________________
Finger or hand numbness	______________________________________
Upper back pain	______________________________________
Lower back pain	______________________________________
Rash under the breasts	______________________________________
Breast Asymmetry	______________________________________
Neck Pain	______________________________________
Shoulder pain	______________________________________
Difficulty fitting into your tops	______________________________________
Need to limit physical activities due to breast size	______________________________________
Need to wear multiple bras or specialty bras	______________________________________

Have you seen a physician, surgeon, chiropractor, or physical therapist because of your back or neck pain?____

Do you need to take pain medications for the pain related to the breasts?_______________________

Do large breasts run in your family?____

If applicable, do we have permission to send photographs of your breasts (without your face) to your insurance company?____

Signature:____

Date:____