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Breast Questionnaire

Patient Name: _____ Date: _____

Have you or anyone in your family ever had any breast disease or breast tumors? Y / N

If yes, please explain. _____
(Type, date of surgery if any, doctor)

What is your height? _____ Weight? _____ What weight do you hope to maintain? _____

How many pounds have you gained in the past 5 years? _____ pounds. Lost? _____ pounds.

How many children have you had? _____ What are their ages? _____

What size bra do you wear? _____ What size bra would you like to wear? _____

Did you breast feed? _____ Bottle feed? _____ Out of choice? Y / N

Did your breasts change size with pregnancy? Y / N If so, how much (in bra size)? _____

Have you had a mammogram? Y / N If yes, when was most recent? _____

Please continue for BREAST REDUCTION and Breast Lift Surgery

Has weight fluctuation significantly affected breast size? Y / N

Please mark any physical symptoms possibly related to size/weight of your breasts:

___neck pain ___back pain ___shoulder pain ___shoulder grooves ___headaches other: _____

Have you had examination or treatment ordered by primary care doctor, chiropractor, orthopedic doctor, or physical therapist, for other possible causes of your pain? Y / N Explain: _____

Have you tried: Wearing a bra all the time: Y / N how long? _____ Chiropractic care: Y / N (if yes, explain below)
Wearing support bras: Y / N how long? _____ Massage Therapy: Y / N (if yes, explain below)
Wearing two bras: Y / N how long? _____ Physical Therapy: Y / N (if yes, explain below)

(DETAILS!) _____

Have you noted skin irritation beneath breasts? Y / N If yes, what is your regimen of treatment? _____

Have you sought treatment from your primary care doctor for these rashes including prescription creams? Y / N

Give detailed information: _____

Does breast size interfere with daily activities or exercise? Y / N explain: _____

Do you ever take prescription medication/ analgesics (aspirin, Tylenol, Motrin, ibuprofen, etc.) for this pain? Y / N

Please continue on back if there is any additional pertinent information related to your situation: ⇨

We may need to contact you and/or any of the above mentioned physicians for documentation for your insurance company. We will need you assistance and cooperation with this process.