



**Female Short Form**

**Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ **Today's Date** \_\_\_\_\_

**1. Do you feel your breasts are too large for your body?**     Yes     No

**2. Have you ever considered breast surgery?**     Yes     No

**2a. If Yes, then for what reason?**

- To increase breast size
- To decrease breast size
- To make both breasts the same size
- Other \_\_\_\_\_

**3. Bra information**

Current bra size: \_\_\_\_\_ (ex. 34B)  
 How long have you been wearing this size? \_\_\_\_\_ years  
 Do you have difficulty finding bras that fit properly?     Yes     No  
 Have you ever been professionally fitted for a bra?     Yes     No

**4. Age when you first noticed breast growth:** \_\_\_\_\_ years old

**5. Breast Symptoms:** Please check any current symptoms you have.

- Breast Pain
- Breast Lump
- Significant difference in breast size
- Nipple Discharge
- Rashes/skin breakdown around or underneath breasts
- Difficulty participating in sports
- Difficulty finding clothes that fit properly

**6. Do you have any of the following as a result of your breasts?** (Please check level of pain, 1=mild,10=severe)

<b>Back Pain</b>	<input type="radio"/> no pain	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10
<b>Neck Pain</b>	<input type="radio"/> no pain	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10
<b>Shoulder Pain</b>	<input type="radio"/> no pain	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10