Peninsula Health

BREAST REDUCTION PATIENT PRE OUTPATIENT ASSESSMENT

PATIENT DETAILS	**PATIENT NAME:**			
	ADDRESS:			
	SUBURB:		**P/CODE:**	
	DATE OF BIRTH:		**AGE:**	

MEDICAL INFORMATION	**HEIGHT:** _____CMS **OR** _____FT _____INCHES		**WEIGHT:** _____KGS
	HAS YOUR WEIGHT CHANGED MORE THAN 4KGS IN THE PAST?	YES NO	**MAXIMUM WEIGHT:** _____ **MINIMUM WEIGHT:** _____
	HAS YOUR WEIGHT BEEN STABLE FOR THE PAST 6 MONTHS?	YES NO	
	CURRENT SYMPTOMS:	BACKACHE HEADACHES NECKACHE BREAST PAIN SHOULDER PAIN RASH BENEATH YOUR BREASTS	
	HAVE YOU HAD ANY TREATMENT FOR THE ABOVE SYMPTOMS?	PHYSIOTHERAPY GP CHIROPRACTIC OTHER: MASSAGE	
	DOES YOUR PROBLEM AFFECT YOUR ACTIVITIES OF DAILY LIVING? (i.e. Wearing clothes, exercising, personal care, social activities)	YES NO	**IF YES, PLEASE SPECIFY?**
	DO YOU SMOKE	YES NO If yes, how many cigarettes per day? _____	

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Please list all medications you take, including any drugs or medicine not prescribed by your doctor.

MEDICATIONS	NAME	DOSE	FREQUENCY

FOR OFFICE USE ONLY	
	☐ Fulfils criteria, for outpatient appointment. Signed _____
	☐ Other _____