KAROL A. GUTOWSKI, MD, FACS

AESTHETIC SURGERY
CERTIFIED BY THE AMERICAN BOARD OF PLASTIC SURGERY
MEMBER AMERICAN SOCIETY OF PLASTIC SURGEONS

Confidential Health Questionnaire for Body Contouring

Includes liposuction, tummy tuck, armlift, thighlift and bodylift

Name _____ Today's Date _____

Age _____ Date of Birth _____ Email _____

Address _____ City_____ ZIP _____

Phone Number _____

Emergency Contact _____ Phone Number _____

Primary Care Physician _____ Phone Number _____

Reason for visit: _____

Which areas are of concern to you?

□ Neck □ Outer thighs (saddle bags) □ Loose skin after large weight loss
□ Arms □ Inner thighs □ Stretch marks in abdomen
□ Breasts □ Front of thighs □ Groin or genitalia
□ Abdomen □ Back of thighs □ Buttock
□ Knees □ Flanks (love handles) □ Other _____

MEDICAL INFORMATION

Allergies □ None
□ Medications _____ Reaction _____
□ Environmental _____ Reaction _____
□ Latex Reaction _____

Medications (including dietary supplements, nonprescription and herbal products)

Past Medical History (list any past or current medical problems)

□ Cold sores or herpes infections

Past Surgical History (list any past procedures & operations, including complications)

□ Implant, pacemaker, defibrillator, or implantable medical device

Social History

Current Occupation _____
Do you smoke or use tobacco? No Yes
Packs per day _____
Year started _____Year stopped _____
Do you drink alcohol? No Yes
Drinks per week _____

Marital Status: Married Single Widowed
Number of children _____
Will any dependents rely on you after surgery? _____
Are you planning on having more children? _____
Who will care for you after surgery? _____
Loss of pregnancies or spontaneous abortions _____

Family Medical History (please explain if any of these conditions have affected a blood relative)

□ Cancer □ Breast Disease □ Heart disease (heart attacks, heart bypass surgery) □ Abnormal reaction to anesthesia

Bleeding or Blood Clotting Disorders

Have you or any blood relative had problems with:

□ Abnormal or excessive bleeding
□ Abnormal or excessive blood clotting, also called Deep Venous Thrombosis (DVT) or Pulmonary Emboli (PE)

Do you have now, or have you been diagnosed as having (if yes, please explain)

□ Stroke
□ Thyroid disease
□ Anemia
□ Arthritis
□ Cancer or tumor
□ Diabetes mellitus
□ Heart attack
□ Heart failure
□ Kidney disease
□ Easy bruising
□ Asthma
□ Varicose veins
□ Seizures
□ Palpitations
□ Hepatitis
□ Hernia
□ Stomach or duodenal ulcer
□ Stomach or intestinal bleeding
□ Irregular or rapid heart beat
□ High blood pressure
□ Frequent gum or nose bleeds
□ Angina or chest pain
□ Jaundice or liver disease
□ Mood disturbance
□ Heart murmurs
□ Shortness of breath or wheezing
□ Frequent heartburn or reflux
□ Fainting or dizziness
□ Nervous breakdown
□ AIDS or HIV positive
□ Immune disorders

Height _____ **Weight** _____ **lbs**

How did you hear about our practice?

□ Internet search □ Doctor □ Friend □ Other _____
□ Television □ Magazine □ Web site _____

Who can we thank for this referral? _____

Completed by _____ **Signature** _____

Section below to be completed by physician

Hernia _____

Impression:

Recommendations:

Signature _____ **Date** _____