

# 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 Gynecomastia

(Includes liposuction and tissue excision of male chest)

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?

Chest       Neck       Abdomen       Flanks (love handles)       Arms       Thighs

Loose skin after weight loss       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 \_\_\_\_\_

Marital Status:    Married    Single    Widowed

Do you smoke or use tobacco?    No    Yes

Number of children \_\_\_\_\_

Packs per day \_\_\_\_\_

Will any dependents rely on you after surgery? \_\_\_\_\_

Year started \_\_\_\_\_ Year stopped \_\_\_\_\_

Are you planning on having more children? \_\_\_\_\_

Do you drink alcohol?    No    Yes

Who will care for you after surgery? \_\_\_\_\_

Drinks per week \_\_\_\_\_

Loss of pregnancies or spontaneous abortions \_\_\_\_\_

Do you use recreational drugs?    No    Yes

**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)

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

Height \_\_\_\_\_ Weight \_\_\_\_\_ lbs

**How did you hear about our practice?**

- |  |                                   |   |                                      |
|--|-----------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Internet search | <input type="checkbox"/> Doctor   | <input type="checkbox"/> Friend         | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Television      | <input type="checkbox"/> Magazine | <input type="checkbox"/> Web site _____ |                                      |

Who can we thank for this referral? \_\_\_\_\_

Completed by \_\_\_\_\_ Signature \_\_\_\_\_

*Section below to be completed by physician*

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**Physical Exam:**

Mass

Discharge

**Impression:**

**Recommendations:**

Signature \_\_\_\_\_

Date \_\_\_\_\_