

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?

- | | | |
|----------------------------------|---|---|
| <input type="checkbox"/> Neck | <input type="checkbox"/> Outer thighs (saddle bags) | <input type="checkbox"/> Loose skin after large weight loss |
| <input type="checkbox"/> Arms | <input type="checkbox"/> Inner thighs | <input type="checkbox"/> Stretch marks in abdomen |
| <input type="checkbox"/> Breasts | <input type="checkbox"/> Front of thighs | <input type="checkbox"/> Groin or genitalia |
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Back of thighs | <input type="checkbox"/> Buttock |
| <input type="checkbox"/> Knees | <input type="checkbox"/> Flanks (love handles) | <input type="checkbox"/> 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
 Packs per day _____ Number of children _____
 Year started _____ Year stopped _____ Will any dependents rely on you after surgery? _____
 Do you drink alcohol? No Yes Are you planning on having more children? _____
 Drinks per week _____ 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)

- | | |
|--|--|
| <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

Hernia _____

Impression:

Recommendations:

Signature _____

Date _____