Martin | Gutowski

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 ______________________

Do you smoke or use tobacco? No Yes

Packs per day ______________________

Year started ________Year stopped ____________

Do you drink alcohol? No Yes

Drinks per week ______________________

Do you use recreational drugs? No Yes

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

Physical Exam:

Mass

Discharge

Impression:

Recommendations:

Signature ____ **Date** ________________