Premier Plastic Surgery Center

Body Contouring Questionnaire

NAME_____DATE_____/_____/20_____
Number of pregnancies_____ Number of deliveries_____
Ever have scoliosis?_____Was it ever treated?_____
Ever smoke?_____How much?_____How many years?_____Quit?_____
Do you snore?.....Yes No
Have you ever been told you stop breathing at night?.....Yes No
Do your arms or legs jerk while sleeping? ……..Yes No
Are you frequently tired upon waking and throughout the day?.Yes No
Do you have trouble staying asleep at night?.....Yes No
Do you feel tired or fall asleep during the day?.....Yes No
Have you ever been diagnosed with Obstructive Sleep Apnea?....Yes No
Do you use a CPAP mask to help you sleep at night?.....Yes No
Do you have arthritis?_____If so, which joints are affected?_____
Do you have any bleeding or clotting disorders?.....Yes No
Have you ever had a blood clot in the deep veins of your legs?....Yes No
Do you take birth control pills or female hormone replacement?..Yes No. If "yes", are you aware that you have increased risks of blood clots?.....Yes No
Would you like to minimize any stretch marks on your body?.....Yes No
Have you ever taken Fen-Phen?_____When?_____How long?_____
What was your lifetime maximum weight?_____Current weight?_____
Height?_____
How has your weight changed in the past 12 months?_____
How often do you exercise?_____
When you work out, what kind of exercise do you do? (e.g. Aerobics? Weight training? Yoga? Etc.)_____
What areas of your body would you like to improve and discuss today? (Please circle all that apply) Neck Arms Chest Back Flanks Abdomen Hips Buttocks Outer thighs Inner Thighs Knees
Of the areas you circled above, which is your highest priority?_____

Please sign here_____Date_____/____/20____

_____OFFICE USE ONLY BELOW THIS LINE_____

NECK _____
ARMS Right._____Left_____
CHEST Circum. _____
BUST Circum._____
ABDOMEN (Mid)_____
ABDOMEN (LOW)_____
HIPS _____
THIGHS Right._____Left_____
KNEES Right._____Left_____

PLAN: NECK LIFT BRACHIOPLASTY (Mini Classic "T" Extended)
LIPO: Neck Arms Chest Back Flanks Abdomen Hips Buttocks Outer thighs Inner thighs Anterior thighs Knees Pubis
ABDOMINOPLASTY: Mini Classic Full Circumferential Vertical
THIGH LIFT (Horiz Vertical) FAT GRAFTING_____
PRE-OP MEDICAL CLEARANCE……Y N
PRE-OP LABS……Y N (lytes, alb, pre-alb, iron, cbc, h/h, ua)