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)

Today's Date: ___________________________

Name _________________________ Middle Name: _________________________ Last Name: __________________________

Age ___________ Date of Birth __________________________ Gender: ___________ Email: ___________________________

Mailing address: ____________________________________ City: ___________ State: ___________ Zip Code: _____________

Allowed forms of communication: (By allowing communication via telephone, I permit Chicago Cosmetic Institute to leave voicemails with persons other than myself)

Phone Number: ______________________________________ Other Phone Number: _________________________________

Emergency Contact __________________________________ 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 □ Stretch marks in _____________________
□ 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)

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

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

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? ________________

Drinks per week ___________________________

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)

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

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

I have read & reviewed

Physician's Signature ____

Physical Exam: Height _______ Weight ______ lbs Hernia ________________

	Lipodystrophy	**Skin tone**		**Lipodystrophy**	**Skin tone**
Neck			Outer thighs		
Arms			Inner thighs		
Abdomen			Anterior thighs		
Breasts			Posterior thighs		
Knees			Flanks		
Back			Chest		

Impression:

Recommendations:

□ Abdominoplasty □ Armlift □ Informed consent □ Second visit offered □ Scars discussed

□ Circumferential □ Thighlift □ Typical results reviewed □ Tobacco cessation □ 5000 cc limit

□ Inverted T □ Bodylift

□ Liposuction □ Neck □ Arms □ Abdomen □ Breast □ Knee □ Back

□ Outer thighs □ Inner thighs □ Anterior thighs □ Posterior thighs □ Flank □ _____________

□ Fat transfer ____

Signature ____ **Date** ____________________

Location ____________________ Anesthesia __________________ Time ______________ Position ______________________

Precautions __________________ Blood ______________________ Equipment ____

Photography and Payment Consent Form

Photography: Before and after photos are an important evidence as to the success of your procedure. The doctors at Chicago Cosmetic Institute do not use these photographs for any purpose unless they have your permission. However, many patients who are contemplating a cosmetic procedure find looking at before and after pictures to be very useful. For this reason, we would like to have your permission to use these photographs. Occasionally, we will use them to post on our website or for marketing purposes. However, we will only use them if we have documented permission from you.

Please circle the appropriate options.

I allow / do not allow Chicago Cosmetic Institute to utilize my photographs for educational purposes

I allow / do not allow Chicago Cosmetic Institute to utilize my photographs on their website.

I allow / do not allow Chicago Cosmetic Institute to utilize my photographs for marketing or advertising.

Payment Policy: Payment for services are due in full at time services are rendered, for self-pay patients, unless otherwise agreed upon. We accept cash, checks and credit cards. If you are interested in financing your treatment, we will be happy to discuss Care Credit options with you.

General Consent to Treatment: I agree and consent to the performance of diagnostic and therapeutic procedures deemed necessary by the physician. I acknowledge that there are no guarantees, expressed or implied, as the result of any procedure or treatment.

I have read the *Notice of Privacy Practices* on (date) ________________________

☐ Yes, I have requested and received a copy
☐ No, I do not wish to receive a copy

I certify that the information listed above is true and correct to the best of my knowledge and that I have read and understand all of the above.

Signature of patient/guardian: _______________________________ **Date**: ____________________

Print name: ____