Abdominal Contour Surgery

Please help us understand you better by completing this form

Pregnancy History:

Number of pregnancies: _____ Number of children you have delivered: _____

Have you had a cesarean section? ____ Yes ____ No If yes, how many? _____

Have you lost weight in the past year? ____ Yes ____ No

If you have lost weight, how much did you weigh prior to your weight loss? _____

Is your weight stable now, or do you plan to lose more weight? ____ Stable ____ Plan to lose more

If your weight is stable now, how long have you been at this weight? _____

Please list your current approximate weight: _____

If you are planning to lose more weight, what is your target weight? _____

Have you undergone surgery to help achieve weight loss? ____ Yes ____ No

If you have undergone surgery, when was the surgery performed? _____

Where was the surgery performed (Hospital, city)? _____

If possible, list the surgeon's name: _____

What type of surgery was performed (please mark the appropriate response):

____ lap. band ____ gastric sleeve

____ laparoscopic roux-en-Y gastric bypass ____ open approach roux-en-Y gastric bypass

____ other (please describe) _____

Did you have any complications related to the surgery? Please list: _____

_____

Please place a mark by any of the following operations you have had on your abdomen:

____ tubal ligation ____ laparoscopic cholecystectomy ____ "open" cholecystectomy

____ appendectomy ____ colon surgery ____ exploratory surgery

____ umbilical hernia ____ inguinal hernia ____ incisional hernia

____ Not applicable. I have not had any surgery on my abdomen

If you were referred to Dr. Kunkel by your primary care physician due to problems you are having with substantial excess lower abdominal skin and are being evaluated to see if your insurance company may cover a surgical procedure to remove that skin, please indicate which of the following problems you may be experiencing:

____ Lower back pain ____ Upper back pain ____ Neck pain

____ Rashes beneath the excess skin of the (circle appropriate areas):

breasts abdomen thighs arms

____ Abscesses/infections requiring treatment by a physician (circle the type therapy received):

antibiotics creams/powders surgical drainage

Please list the physician who treated you: _____

Signature _____ Date _____