

# **BODY SURGERY HISTORY**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Last) (First) (M.I)

What is the reason for your visit today? \_\_\_\_\_

What in particular about your body concerns you at this time? \_\_\_\_\_

Is there a family history of this particular condition? \_\_\_\_\_

Are you familiar with the surgical procedure you wish to discuss? \_\_\_\_\_

Have you had previous Cosmetic Surgery? \_\_\_\_\_

If so, what and when? \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Please describe weight changes you have experienced in the last year or two:  
\_\_\_\_\_

Do you have a regular exercise program? \_\_\_\_\_

If so, please describe: \_\_\_\_\_

How would you consider your general health? \_\_\_\_\_

How would you consider your skin elasticity and tone quality? \_\_\_\_\_

Do you have any current skin ailments or concerns? \_\_\_\_\_

Have you ever had difficulty with large scars or keloids? \_\_\_\_\_

Is there anything in particular we need to know about your health? \_\_\_\_\_

Current Medications: \_\_\_\_\_

Have you seen another doctor for treatments of this condition? \_\_\_\_\_

If so, who and when: \_\_\_\_\_

## **FEMALE PATIENTS:**

What age did you begin to menstruate? \_\_\_\_\_ Are your periods regular? \_\_\_\_\_

How many times have you been pregnant? \_\_\_\_\_ How many children? \_\_\_\_\_

Ages: \_\_\_\_\_ Did you have a Cesarean Section? \_\_\_\_\_

Do you anticipate future pregnancies? \_\_\_\_\_

Thank you