

Abdominoplasty Evaluation Form

-Name:

-Who referred you to Surgical Services PC?

-What is your main area of concern?

- Loose skin upper/lower abdomen
- Flank fullness
- Bulges
- Other:

-Have you ever had abdominal surgery? Yes / No

-To your best knowledge, do you have an abdominal wall hernia? Yes / No

-Have you ever had a cosmetic surgery/procedure before? Yes / No

If yes, please list:

Procedure	Year

-What is your fitness/activity level (what do you do for exercise and how often)?

-What is your main reason for wanting a tummy tuck?

-Have you ever been pregnant? Yes/ No

-Do you plan to be pregnant in the future? Yes/ No

-Are you losing or gaining weight? Losing / Gaining / Steady
If steady, how long has it been steady for?

-Are you happy with your current weight? Yes / No
-Can you maintain your current weight? Yes / No
-what nutritional supplements do you use?

-Do you have any other areas of concern you would like to discuss today?

-Do you have a personal or family history of:

- Bleeding disorder
- Blood clots
- Hyperthermia

-Who will help you during your recovery period?

