

Panniculectomy Evaluation Form

-Name:

-Who referred you to Surgical Services PC?

- Do you have a skin rash under your pannus? Yes / No
- Were you ever treated with prescription or over the counter medications for a rash under your pannus? Yes / No
- Does your pannus prevent you from exercising? Yes / No
- Do you have trouble fitting clothes due to your pannus? Yes / No
- Does your pannus interfere with your ability to use a bathroom? Yes / No
- Does your pannus interfere with your ability to have sexual activity? Yes / No
- 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 done before? Yes / No

If yes, please list:

Procedure	Year

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

- 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
- Are you happy with your current weight? Yes / No
- How long has your weight been stable?

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

-Do you have personal or family history of:

- Malignant hyperthermia
- Bleeding disorder
- Blood clots

-Who will help you during your recovery period?
