CHICAGO COSMETIC INSTITUTE

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
- ☐ Arms
- ☐ Breasts
- ☐ Abdomen
- ☐ Knees
- ☐ Outer thighs (saddle bags)
- ☐ Inner thighs
- ☐ Front of thighs
- ☐ Back of thighs
- ☐ Flanks (love handles)
- ☐ Loose skin after large weight loss
- ☐ Stretch marks in abdomen
- ☐ Stretch marks in _____
- ☐ Buttock
- ☐ 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

Drinks per week _____

Do you use recreational drugs? 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? _____

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: _____