HISTORY OF THE ABDOMEN

Name _____ Date _____

Date of Birth _____ Age _____

1. How many pregnancies have you had? _____ Live births? _____

2. Are you planning any more pregnancies? Yes ___ No ___When? _____

3. Previous abdominal surgeries (including laproscopic, C-Sections, Bariatric etc.) _____

_____

_____

4. Do you smoke? Yes ___ No ___

5. Are you at your desired weight? _____

6. Do you plan on losing weight? Yes ___ No ___

If yes, how much are you planning to lose? _____

7. Have you lost weight? Yes ___ No ___ How much have you lost? _____

8. How did you obtain this weight loss? _____

9. How long have you maintained your goal weight? _____

10. What are you unhappy with in regards to your abdomen? _____

_____

The above information is accurate and true to the best of my knowledge. I have not purposely left out pertinent information or given inaccurate information.

PATIENT'S SIGNATURE_____ DATE _____