Contouring Questionnaire

Name: _____ Date: _____

1. From what areas are you interested in having fat removed?

   Face/Neck _____ Arms _____

   Breasts _____ Abdomen _____

   Waist _____ Hips _____

   Buttocks _____ Thighs _____

   Knees _____ Ankles _____

   Other _____

2. Why? _____
3. What is your height? _____ Weight? _____
4. Have you gained or lost weight in the last year? _____

   How much? _____
5. In the last five years? _____ How much? _____
6. If you are a female, how many children have you had? _____

   Ages? _____
7. Do you bruise easily or have a bleeding tendency? _____
8. Have you ever had phlebitis (blood clots)? _____
9. Please list any drug allergies: _____

_____

10. What medications are you currently taking? _____

_____

11. What is your clothing size? (male waist, female dress) _____
12. What are your expectations? _____

_____

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