Abdominal Body Contouring Consultation Dean P Kane, MD, FACS, PA

Name: _____ Age:_____ Date:_____

Thank you for choosing our office for your consultation! Please check or fill in the following information so I may better help you.

Are you pregnant? Y N Do you have a "COLD" skin / blood disease? Y N

List and date any prior abdominal surgery, hernia repairs or injury:

Height: , Weight: . Pregnancies: , # children: , Miscarriage(s): , Abortion(s): .

Have you smoked tobacco at any time in the past 12 months? Y N

Circle the use of any weight reduction or diet / exercise program / diet medication or supplement

Prior Fat Reduction: liposuction, Thermage, Zerona, external ultrasound, CoolSculpting, other:

Dietary Intake:
CHO
Protein
Other: