Aesthetic Consultants of Iowa Charles E. Grado, M.D.
3705 River Ridge Drive N.E. Cedar Rapids, Iowa 52402

Abdominal Information Record

please complete this for your record

Name ____***Date***_______________________

Age:_________ Height:__________ Current Weight:__________ Maximum weight_______________

5 year minimum weight_________ 5 year maximum weight________ Desired goal weight_____________

Do you have problems with rashes beneath your belly? _______ Are they chronic/intermittent (circle one)
If so, how are they treated and by whom?

____

Do you have any problems with back pain?_________ If so, for how long?___________. How is it treated and by whom?____
____

__Have you undergone surgery for morbid obesity? If so, please complete below:

Where done____________________Date_______ By Whom:_____________________________________

History of thrombophlebitis_________ Blood clots___________Pulmonary embolus____________

Have you had any other abdominal surgeries? If so, complete below:

Procedure:______________________Date________ Procedure:______________________Date__________

Procedure:______________________Date________ Procedure:______________________Date__________

WOMEN ONLY

Number of pregnancies_________ Ages of children__________________________
Do you plan on having any more children?__________________