Panniculectomy Questionnaire

Height: _____ Weight: _____

Do you experience the following symptoms:

Rashes beneath abdominal skin (Y/N) How often? _____

Difficulty with physical activity/exercise (Y/N) How often? _____

Have you had recent weight loss? (Y/N) How much? _____

Is weight stable? (Y/N) How long? _____

Have you tried any of the following treatments for your symptoms:

Ointments/sprays for rashes (Y/N) How long? _____ Provided Relief? Y / N

Supportive undergarments (Y/N) How long? _____ Provided Relief? Y / N

Over-the-counter medications (Y/N) How long? _____ Provided Relief? Y / N

Prescription medications (Y/N) How long? _____ Provided Relief? Y / N

Gastric surgery for weight loss? (Y/N)

List them: _____

When? _____

In your own words, please describe the reasons you feel the surgery is medically necessary (the psychological effects of having a large panniculus do not support the medical need for a surgery). If space is insufficient, add notes on the back of this page.

_____

_____

_____

_____ _____ _____

Patient Name Signature Date

Please note, some insurance carriers will require documentation to support medical necessity. It is the patient's responsibility to obtain documentation. We will notify you if any such documentation is needed.

How would you prefer we contact you if necessary? Email / Phone / Mail