

NAME: _____ TODAY'S DATE: _____ DATE OF BIRTH: _____ AGE: _____

REVIEW OF SYSTEMS:

Please answer each of the following as if the question begins with "Are you":

Constitutional:

- 1. feeling weak / tired all the time? No Yes
- 2. having trouble sleeping? No Yes
How many hours do sleep a night? _____
- 3. gaining / losing weight? (circle one) No Yes
How many lbs a month? _____
Since when? (month, year) _____
- 4. having fevers / chills? No Yes
- 5. Do you exercise at least 30 min per day? No Yes
Type of exercise? _____ How often? _____ min per day, _____ per week

Eye, Ear, Nose, Throat:

- 1. having mouth sores? No Yes
- 2. having visual problems? (e.g. @ night) No Yes

Cardiovascular:

- 1. having a problem with swelling of (circle) arms/ legs/ ankles?
- 2. having palpitations/racing heart beats? No Yes
- 3. having chest pains? No Yes
- 4. having fainting spells? No Yes
- 5. short of breath climbing stairs? No Yes
How many stairs? _____
- 6. having problems with blood pressure? No Yes
- 7. having calf pain? No Yes

Respiratory:

- 1. having wheezing? No Yes
- 2. short of breath? No Yes
- 3. having problems with sleep apnea? No Yes
Using a CPAP/Bi.PAP machine? No Yes

Gastrointestinal/Abdominal:

- 1. having a problem with nausea? No Yes
- 2. vomiting No Yes
- 3. regurgitating (feedback)? No Yes
- 4. vomiting blood? No Yes
- 5. having heartburn? No Yes
- 6. having indigestion? No Yes
- 7. having abdominal pain? No Yes

Where? _____
How long? _____

- 8. having a "bulging" at the incision? No Yes
- 9. having a problem with diarrhea? No Yes
Times/day _____ Times/week _____
- 10. constipated? No Yes
Last bowel movement _____ day(s) ago
My stools are: ↑ formed ↑ hard

- 11. having blood in your stools? No Yes

Musculoskeletal:

- 1. having pain in any of the following areas?
Back No Yes Knee No Yes
Hip No Yes Ankle No Yes
Neck No Yes Shoulder No Yes
Wrist No Yes Arm No Yes
- 2. experiencing fibromyalgia? No Yes
- 3. experiencing carpal tunnel syndrome? No Yes

FOR PATIENTS WITH ADJUSTABLE GASTRIC BANDS:

Describe the largest amount you can eat in 30 min (e.g., a Big Mac / 6" Sub)

- 1. Check first if you CAN eat. Check second if you have NOT TRIED:
 red meat pasta white bread sticky rice
- 2. Do you feel your band is restricted? No Yes
- 3. Any recent change in the amount you can eat? No Yes
- 4. Do you still feel very hungry? No Yes
- 5. Are you consuming sugar? No Yes
- 6. Are you consuming milk? No Yes
- 7. Are you taking in liquids & food at the same time? No Yes
- 8. Are you on appetite suppressants? No Yes
Phentermine (Fastin) dose _____ Duration _____
- 9. Do you have port site tenderness? No Yes
- 10. Has anyone besides SWLC adjusted your band? No Yes
If yes, who? _____
- 11. Has your heartburn recurred? No Yes

Integumentary/Breast:

- 1. losing excessive amounts of hair? No Yes
- 2. having a rash under breasts? No Yes
abdominal fold? No Yes
Seen a dermatologist? No Yes
- 3. having problems with the wound/ scar? No Yes
 Fluid/Pus Redness Excessive tenderness
- 4. having wound drain problems? No Yes
 Pulled out too much Painful Site is red
- 5. having breast lumps or nipple discharge? No Yes

Neurological:

- 1. having trouble with balance/coordination No Yes
Been in the ER because of falls? No Yes
- 2. having recurrent headaches? No Yes
- 3. having seizures? No Yes
- 4. having episodic weakness? No Yes
- 5. having numbness / tingling? No Yes
- 6. having pain down the thigh/ leg /arm? (circle) No Yes
- 7. having memory loss? No Yes

Psychiatric:

- 1. depressed? No Yes
 Suicidal No Yes
- 2. stressed? No Yes
From: Spouse Significant other
 Family Friends Finances Job

Endocrine:

- 1. having problems with:
- sugar control (diabetes)? No Yes
On insulin? No Yes
- your thyroid gland? No Yes
On medication? No Yes
- cholesterol/ triglycerides? No Yes
On medication? No Yes
- 2. having numbness / tingling? No Yes
Where? _____ Spasms? Where? _____

Hematologic/Lymphatic:

Do you have a history of anemia? No Yes

Genitourinary:

- 1. having urinary leaks coughing/sneezing? No Yes
- 2. having difficulty voiding? No Yes

Gynecological:

Birth Control: _____ Last period _____
Date of last pap exam: _____ Normal Abnormal
If abnormal, is there a history of abnormal? No Yes
How many pregnancies? _____ Births? _____
Vaginal Delivery? _____ C-Sections? _____
Having problems with menstruation? No Yes

Allergies:

- 1. having allergy symptoms? No Yes
- 2. allergic to (please circle which one/s) No Yes
medications/ supplements/ food/ LATEX / contrast dye / iodine
List: _____

SOCIAL HISTORY:

Marital Status: _____
Current Occupation: _____
Past or current use of:
Tobacco products No Yes
Alcohol No Yes
Recreational drugs No Yes
Do you attend Support Group meetings? No Yes
Date last attended: _____
Where? _____

The information I have given on this form is both correct and complete to the best of my ability. I understand that I am financially responsible for all the charges for this visit.

Patient Signature _____

