CENTER FOR WEIGHT LOSS SURGERY
34509 9th Avenue S, Suite 103, Federal Way, WA 98003 • 12303 NE 130th Lane, Suite 120, Kirkland, WA 98034
p: 253-815-7774 (toll free: 877-815-7774) • f: 253-815-7708 • www.c4wls.com

Comprehensive Patient History

PERSONAL INFORMATION

Name: _____ Date of Birth (DOB): _____ Age: _____ Gender: _____
First MI Last

Address: _____ Home Phone: _____ Cell Phone: _____

City: _____ State: _____ Zip: _____ Social Security #: _____

Patient Email: _____ Spouse/Partner Name: _____

► **Please indicate whether you would like to receive our monthly email newsletter:** ❑ Yes ❑ No

Ethnicity (optional): ❑ White ❑ Hispanic ❑ Black ❑ Asian ❑ Native American ❑ Other: _____

Name, **Address** and **Phone Number** of two relatives NOT living with you:

1._____ Relationship: _____

2._____ Relationship: _____

Patient Occupation: _____ Employer: _____ ❑ Full Time ❑ Part Time

Patient Work Phone (if ok to contact): _____ Patient Work Email (if ok to contact): _____

Spouse/Partner Occupation: _____ Employer: _____ City: _____

Spouse/Partner Work Phone (if ok to contact): _____ Spouse/Partner Work Email (if ok to contact): _____

PRIMARY Insurance Company: _____

Subscriber Name: _____ Sub. DOB: _____

Subscriber/ID #: _____ Plan: _____

Group #: _____ Ins. Phone: _____

Sub. Address: _____

SECONDARY Insurance Company: _____

Subscriber Name: _____ Sub. DOB: _____

Subscriber/ID #: _____ Plan: _____

Group #: _____ Ins. Phone: _____

Sub. Address: _____

HEALTH CARE PROVIDER

Primary Care Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

► **Day of Surgery Information:**

Name of person to notify immediately following surgery: _____ _____ Relationship: _____

Will he/she be waiting at the hospital during your surgery? ❑ No ❑ Yes If NO, check where to call on next line:

❑ Home Phone: _____ ❑ Work Phone: _____ ❑ Cell Phone: _____

Who will be with you during hospitalization and discharge? _____

► **Out of Town Patients:** It is <u>very</u> important that you have someone with you who can assist you.

If you should have a serious perioperative condition such as stroke, heart attack or lung failure,
do you wish to be resuscitated? ❑ Yes ❑ No

Mechanically? ❑ Yes ❑ No

Chemically? ❑ Yes ❑ No

Maintained on a ventilator? ❑ Yes ❑ No

Have you notified your family of your request? ❑ Yes ❑ No

Do you have an ADVANCED DIRECTIVE? ❑ Yes ❑ No If YES, where? _____

Please list any individuals to whom we **MAY GIVE** information (other than physicians) regarding your medical records/condition:

Name	Relationship
_____	_____
_____	_____

Patient Name: _____

OBESITY HISTORY

Obesity has been a problem for _____ years, since: ❑ Childhood ❑ Teenage Years ❑ Adult Years ❑ Pregnancy

Current Weight: _____ Height: _____ BMI: _____ *(see BMI insert for instructions)*

Based on your daily experience, please answer the following questions:				
		Yes	**No**	**Comment (optional)**
1.	Has your weight affected your interpersonal relationships in any of the following areas: social gatherings and meeting new people; being seen in public; being mistreated, teased or ridiculed; not having friends.			
2.	Has your weight affected your attitude, abilities, performance or career at work?			
3.	Has your weight affected your daily mobility such as getting dressed, rising from furniture, awkwardness or clumsiness, fastening shoes or clothing, bending over?			
4.	Are you wheelchair bound because of weight?			
5.	Do you have handicap parking privileges because of weight?			
6.	Has your weight affected your self-esteem so that any of the following comments are true: you are afraid to "have fun"; be assertive; feel moody and out of control; you will not spend money on yourself; worry about weight a lot of the time; won't look in mirrors; have trouble with personal hygiene?			
7.	Has your weight affected your sex life and intimacy in any of the following ways: you do not want to be seen undressed; have no sexual desire; have physical difficulty with sex; you avoid sexual relationships; no longer enjoy sexual activity.			
8.	Has your weight affected your ability to find clothes that fit?			
9.	Has your weight made it difficult to find chairs or seating in public places, people's homes, public transportation?			
10.	Has your weight made it difficult for you to maneuver in public facilities/accommodations where there are aisles or turnstiles, or in public restrooms?			

► Food Habits:

I am satisfied when I finish eating a meal.	❑ Yes ❑ No	I snack between meals.	❑ Yes ❑ No
I use food as a source of comfort.	❑ Yes ❑ No	I eat some sweets every day.	❑ Yes ❑ No
I am not concerned about how much I eat.	❑ Yes ❑ No	I binge eat.	❑ Yes ❑ No
I am not concerned about the types of food I eat.	❑ Yes ❑ No	I snack all day long.	❑ Yes ❑ No
I think a lot about food during the day.	❑ Yes ❑ No	I go without then gorge myself.	❑ Yes ❑ No
How many times per day do you eat?	_____	I eat normal size meals 3x daily.	❑ Yes ❑ No

► Weight Loss Drugs:

Please indicate all weight loss drugs you have used in the past including herbal/homeopathic and over-the-counter:

Fen-Phen	❑ Yes ❑ No	Xenecal®	❑ Yes ❑ No
Phentermine (Fastin®)	❑ Yes ❑ No	Pondimin®	❑ Yes ❑ No
Meridia®	❑ Yes ❑ No	Others (include all): _____	

► Please indicate which diet programs you have tried by answering NO or YES to each of the diet programs listed:

Book Diets	❑ Yes ❑ No	Self-Imposed Fasts	❑ Yes ❑ No	The Diet Center	❑ Yes ❑ No
Magazine Diets	❑ Yes ❑ No	Herbal Life	❑ Yes ❑ No	Curves	❑ Yes ❑ No
Over-the-Counter	❑ Yes ❑ No	High Protein	❑ Yes ❑ No	Hypnosis	❑ Yes ❑ No
Air Force Diet	❑ Yes ❑ No	Liquid Protein	❑ Yes ❑ No	Inches-A-Weigh	❑ Yes ❑ No
Dr. Atkins	❑ Yes ❑ No	Low Carbohydrate	❑ Yes ❑ No	Jenny Craig	❑ Yes ❑ No
Pritikin Diet	❑ Yes ❑ No	Low Calorie	❑ Yes ❑ No	LA Weight Loss	❑ Yes ❑ No
Personal Trainer	❑ Yes ❑ No	Medifast	❑ Yes ❑ No	Overeaters Anon.	❑ Yes ❑ No
Athletic Club	❑ Yes ❑ No	Nutri-System	❑ Yes ❑ No	TOPS Club	❑ Yes ❑ No
Bally's Program	❑ Yes ❑ No	Optifast	❑ Yes ❑ No	Virginia Mason	❑ Yes ❑ No
LA Fitness Club	❑ Yes ❑ No	Slim Fast	❑ Yes ❑ No	Weight Watchers	❑ Yes ❑ No
Living Well Lady	❑ Yes ❑ No	Subway	❑ Yes ❑ No	Mayo Clinic	❑ Yes ❑ No
Toppfast	❑ Yes ❑ No				

Patient Name: _____

► **PHYSICIAN SUPERVISED DIET**: Insurance companies' definition of Physician Supervised Diet means that you have gone monthly to your physician, specifically for weight loss. If you have participated in this type of diet, please check how long you did a program.

❑ 3 months ❑ 6 months ❑ 9 months ❑ 12 months ❑ More than a year

Did you participate in this Physician Supervised Program within the last two years from today's date? ❑ No ❑ Yes

► **PERSONAL GOALS:** (Please summarize.)

Why do you want weight loss surgery?	What do you think your ideal weight and size should be?	What do you think you need to do to reach your goal?

HISTORY OF PRESENT ILLNESS

If you **currently have**, or you **have had** problems with any of the following conditions, indicate how long it has been a problem and if you have had a physician diagnose and/or treat the problem. Please check (✓) EVERY box YES or NO

RESPIRATORY	**How Long?**	**Diagnosed?**	**Treatment?**
Shortness of breath on exertion	_____	❑ Yes ❑ No	❑ Yes ❑ No
(Clinical Obesity Hypoventilation Syndrome)			
Walk 3 city blocks without stopping?	❑ Yes ❑ No		
If NO, can you walk with cane or crutch?	❑ Yes ❑ No	❑ Wheel Chair bound?	
Do you use oxygen at home?	❑ Yes ❑ No		
Do you have sleep apnea?	_____	❑ Yes ❑ No	❑ Yes ❑ No
If yes, pressure setting:			
Using CPAP: _____ _____			
Using BiPAP: _____ _____			
Snoring disturbs the sleep of others			
❑ Never ❑ Rarely ❑ Occasionally (1-3 times/week) ❑ Frequently (3 or more times/week)			
Been told that you pause or stop breathing during sleep			
❑ Never ❑ Rarely ❑ Occasionally (1-3 times/week) ❑ Frequently (3 or more times/week)			
	How Long?	**Diagnosed?**	**Treatment?**
Epworth Sleep Score Total (see box→)	_____	❑ Yes ❑ No	❑ Yes ❑ No
Wheezing on exertion	_____	❑ Yes ❑ No	❑ Yes ❑ No
Orthopnea (Shortness of breath lying flat)	_____	❑ Yes ❑ No	❑ Yes ❑ No
How many pillows under head to sleep	_____		
Do you sleep sitting up?	❑ Yes ❑ No		
Asthma	_____	❑ Yes ❑ No	❑ Yes ❑ No
ER visit for asthma?	❑ Yes ❑ No		❑ Yes ❑ No
Pulmonary Hypertension	_____	❑ Yes ❑ No	❑ Yes ❑ No

Epworth Sleepiness Scale

Choose one of the following numbers to describe each situation listed below:

0 = would never doze or sleep
1 = slight chance of dozing or sleeping
2 = moderate chance of dozing or sleeping
3 = high chance of dozing or sleeping

___ Sitting and reading
___ Watching TV
___ Sitting inactive in a public place
___ As a passenger in any transportation for an hour or more
___ Lying down in the afternoon
___ Sitting and talking to someone
___ Sitting quietly after lunch (no alcohol)
___ Stopped for a few minutes in traffic while driving

_____ **Total scores**

This is your Epworth Sleep Score

CARDIOVASCULAR	**How Long?**	**Diagnosed?**	**Treatment?**
Heart Attack	_____	❑ Yes ❑ No	❑ Yes ❑ No
Angina – Chest pain	_____	❑ Yes ❑ No	❑ Yes ❑ No
Coronary Artery Disease	_____	❑ Yes ❑ No	❑ Yes ❑ No
Heart Valve Disease: please ✓ which condition	_____	❑ Yes ❑ No	❑ Yes ❑ No
Mitral Valve: ❑ Regurgitation ❑ Prolapse ❑ Stenosis			
Aortic Valve: ❑ Regurgitation ❑ Prolapse ❑ Stenosis			
Heart Failure	_____	❑ Yes ❑ No	❑ Yes ❑ No
Enlarged Heart	_____	❑ Yes ❑ No	❑ Yes ❑ No
Cardiomyopathy	_____	❑ Yes ❑ No	❑ Yes ❑ No
Heart Rhythm Abnormality:			
Atrial Fibrillation	_____	❑ Yes ❑ No	❑ Yes ❑ No
Ventricular Fibrillation	_____	❑ Yes ❑ No	❑ Yes ❑ No
Ventricular Tachycardia	_____	❑ Yes ❑ No	❑ Yes ❑ No
Auto Implanted Cardiac Defibrillator (AICD)	_____	❑ Yes ❑ No	❑ Yes ❑ No
Hypertension	_____	❑ Yes ❑ No	❑ Yes ❑ No

HISTORY OF PRESENT ILLNESS *(continued)*

NEUROLOGIC	**How Long?**	**Diagnosed?**	**Treatment?**
Stroke	_____	❑ Yes ❑ No	❑ Yes ❑ No
Carotid Artery Disease	_____	❑ Yes ❑ No	❑ Yes ❑ No
TIA-Transient Ischemic Attacks/ Temporary Blindness		❑ Yes ❑ No	❑ Yes ❑ No
VENUS THROMBO EMBOLIC DISEASE	**How Long?**	**Diagnosed?**	**Treatment?**
Deep Vein Thrombosis (DVT)	_____	❑ Yes ❑ No	❑ Yes ❑ No
❑ Left leg ❑ Right leg ❑ Both legs			
Pulmonary Embolism (PE)	_____	❑ Yes ❑ No	❑ Yes ❑ No
ENDOCRINE			
Diabetes Mellitus	_____	❑ Yes ❑ No	❑ Yes ❑ No
On insulin? ❑ Yes ❑ No	_____		
Diabetic Retinopathy	_____	❑ Yes ❑ No	❑ Yes ❑ No
Diabetic Neuropathy	_____	❑ Yes ❑ No	❑ Yes ❑ No
Diabetic Nephropathy	_____	❑ Yes ❑ No	❑ Yes ❑ No
During pregnancy		❑ Yes ❑ No	❑ Yes ❑ No
High Blood Sugar	_____	❑ Yes ❑ No	❑ Yes ❑ No
Insulin Resistance Syndrome	_____	❑ Yes ❑ No	❑ Yes ❑ No
Metabolic Syndrome	_____	❑ Yes ❑ No	❑ Yes ❑ No
Hypothyroidism	_____	❑ Yes ❑ No	❑ Yes ❑ No
Elevated Cholesterol	_____	❑ Yes ❑ No	❑ Yes ❑ No
Elevated Triglycerides	_____	❑ Yes ❑ No	❑ Yes ❑ No
VENOUS			
Swelling of the ankles or legs	_____	❑ Yes ❑ No	❑ Yes ❑ No
Varicose Veins	_____	❑ Yes ❑ No	❑ Yes ❑ No
Venous Stasis Ulcers/Pigmentation	_____	❑ Yes ❑ No	❑ Yes ❑ No

GASTRINTESTINAL

Heartburn	❑ Yes ❑ No
Reflux	❑ Yes ❑ No
Hiatal Hernia	❑ Yes ❑ No
Gall Stones	❑ Yes ❑ No
Upper abdominal pain	❑ Yes ❑ No

MUSCULOSKELETAL

Arthritis		❑ Yes ❑ No
Low back pain (Sciatica):		❑ Yes ❑ No
Pain radiates down to right lower leg		❑ Yes ❑ No
Pain radiates down to left lower leg		❑ Yes ❑ No
Pain radiates down to both legs		❑ Yes ❑ No
Pain/numbness/tingling in weight-bearing joints:		❑ Yes ❑ No
Hips:	Right	❑ Yes ❑ No
	Left	❑ Yes ❑ No
Knees:	Right	❑ Yes ❑ No
	Left	❑ Yes ❑ No
Ankles:	Right	❑ Yes ❑ No
	Left	❑ Yes ❑ No
Feet:	Right	❑ Yes ❑ No
	Left	❑ Yes ❑ No
Joint replacement:		
	Right hip	❑ Yes ❑ No
	Left hip	❑ Yes ❑ No
	Right knee	❑ Yes ❑ No
	Left knee	❑ Yes ❑ No
Carpal Tunnel Syndrome:		
	Right hand or wrist	❑ Yes ❑ No
	Left hand or wrist	❑ Yes ❑ No
	Both hands/wrists	❑ Yes ❑ No

GENITOURINARY

Urinary stress incontinence	❑ Yes ❑ No
Wear pads for protection	❑ Yes ❑ No
Polycystic Ovarian Syndrome	❑ Yes ❑ No
Infertility	❑ Yes ❑ No

PSYCHOLOGICAL

Depression	❑ Yes ❑ No

SKIN

Hirsutism (excessive facial hair)	❑ Yes ❑ No
Intertrigenous Dermatitis (Rash under breasts, abdominal folds, groin)	❑ Yes ❑ No
Scars	❑ Yes ❑ No

Patient Name: _____

PRIOR WEIGHT LOSS SURGERY

► **NOTE: If you have had any type of <u>weight lost surgery</u> before, we MUST have the Operative Reports prior to your initial consultation.** *Use the "Release of Information Authorization" to have the report sent to our office.*

Weight before surgery _____ lbs. Height before surgery _____
Lost down to what weight _____ lbs. Height after weight loss _____

WEIGHT LOSS SURGERY		Date	Surgeon	Reason for Surgery
Gastric Bypass:				
Distal Bypass	❑ Open ❑ Laparoscopic			
Medial Bypass	❑ Open ❑ Laparoscopic			
Proximal Bypass	❑ Open ❑ Laparoscopic			
Duodenal Switch	❑ Open ❑ Laparoscopic			
Adjustable Gastric Band:	❑ Open ❑ Laparoscopic			
Vertical Banded Gastroplasty				
Other				

REVIEW OF SYSTEMS (Please answer every question by checking (✓) each box.

Constitutional:
Weakness ❑ Yes ❑ No
Fatigue ❑ Yes ❑ No
Chronic Fatigue Syndrome ❑ Yes ❑ No
Narcolepsy ❑ Yes ❑ No
Restless Leg Syndrome ❑ Yes ❑ No
Periodic limb movements ❑ Yes ❑ No

Eyes:
Temporary blindness ❑ Yes ❑ No
Recent change in vision ❑ Yes ❑ No
Double vision ❑ Yes ❑ No
Floaters/spots ❑ Yes ❑ No
Cataract ❑ Yes ❑ No

Ears:
Ear pain ❑ Yes ❑ No
Ear infections ❑ Yes ❑ No
Excessive discharge ❑ Yes ❑ No
Hearing problems ❑ Yes ❑ No
Acoustic Neuroma ❑ Yes ❑ No
Benign Positional Vertigo ❑ Yes ❑ No

Nose, Throat, Mouth:
Bloody nose ❑ Yes ❑ No
Nasal congestion ❑ Yes ❑ No
Loss of smell ❑ Yes ❑ No
Dental problems ❑ Yes ❑ No
Sores in mouth ❑ Yes ❑ No
Loss of taste ❑ Yes ❑ No

Cardiovascular:
Low Blood Pressure ❑ Yes ❑ No
Heart Murmur ❑ Yes ❑ No

Cardiovascular (cont.):
Palpitation ❑ Yes ❑ No
Fainting spells ❑ Yes ❑ No
Limb pain when walking ❑ Yes ❑ No
Pain instep/sole @ rest ❑ Yes ❑ No
Rheumatic fever ❑ Yes ❑ No
Peripheral Vascular Disease ❑ Yes ❑ No

Respiratory:
Excessive phlegm ❑ Yes ❑ No
Chronic cough ❑ Yes ❑ No
(more than 3 months)
Lung Cancer ❑ Yes ❑ No
Sarcoidosis ❑ Yes ❑ No
Mesothelioma ❑ Yes ❑ No
COPD (Chronic Obstructive Pulmonary Disorder) ❑ Yes ❑ No
Emphysema ❑ Yes ❑ No
Tuberculosis ❑ Yes ❑ No
Histoplasmosis ❑ Yes ❑ No

Gastrointestinal:
Voice hoarse ❑ Yes ❑ No
Cough at night ❑ Yes ❑ No
Abdominal pain ❑ Yes ❑ No
Type of pain:
Sharp ❑ Yes ❑ No
Dull ❑ Yes ❑ No
Hot ❑ Yes ❑ No
Cold ❑ Yes ❑ No
Aching ❑ Yes ❑ No
Crushing ❑ Yes ❑ No
Indicate where on picture:
Diagram will be done in the office.

Gastrointestinal (cont.):
When does pain begin?
Before eating ❑ Yes ❑ No
During eating ❑ Yes ❑ No
After eating ❑ Yes ❑ No
Frequency:
Daily ❑ Yes ❑ No
1-2 times/week ❑ Yes ❑ No
8+ times/week ❑ Yes ❑ No
Trouble swallowing: ❑ Yes ❑ No
Liquids ❑ Yes ❑ No
Solids ❑ Yes ❑ No
Vomiting ❑ Yes ❑ No
Nausea ❑ Yes ❑ No
Bloody stools ❑ Yes ❑ No
Diarrhea ❑ Yes ❑ No
Constipation: ❑ Yes ❑ No
Use laxatives ❑ Yes ❑ No
Use enemas ❑ Yes ❑ No
Barrett's Esophagus ❑ Yes ❑ No
Gastric Ulcer ❑ Yes ❑ No
Duodenal Ulcer ❑ Yes ❑ No
Crohn's Disease ❑ Yes ❑ No
Celiac Sprue ❑ Yes ❑ No
Ulcerative Colitis ❑ Yes ❑ No
Colitis ❑ Yes ❑ No
Spastic Colon ❑ Yes ❑ No
Irritable Bowel Syndrome ❑ Yes ❑ No
Hemorrhoids ❑ Yes ❑ No
Colon Polyps ❑ Yes ❑ No
Colon Cancer ❑ Yes ❑ No

Patient Name: _____

Liver Disease
- Hepatitis B ❑ Yes ❑ No
- Hepatitis C ❑ Yes ❑ No
- Cirrhosis ❑ Yes ❑ No
- Steato Hepatitis Non-Alcoholic Steato Hepatitis (NASH) ❑ Yes ❑ No
- Fatty Liver ❑ Yes ❑ No

Genitourinary:
- Difficulty urinating ❑ Yes ❑ No
- Blood in urine ❑ Yes ❑ No
- Kidney stones ❑ Yes ❑ No
- Kidney failure ❑ Yes ❑ No
- Kidney insufficiency ❑ Yes ❑ No
- Dialysis ❑ Yes ❑ No

Genitourinary—Men:
- Testicular Pain ❑ Yes ❑ No
- Testicular Swelling ❑ Yes ❑ No
- Impotency ❑ Yes ❑ No
- Prostate enlargement ❑ Yes ❑ No
- Prostatic Cancer ❑ Yes ❑ No

Genitourinary—Women:
- Last menstrual period ❑ Yes ❑ No
- Heavy menstrual flow ❑ Yes ❑ No
- Ever been pregnant? ❑ Yes ❑ No
- Age at first pregnancy _____
- How many pregnancies? _____
- Birth Control: ❑ Yes ❑ No
  - Pills ❑ Yes ❑ No
  - IUD ❑ Yes ❑ No
- Perimenopausal ❑ Yes ❑ No
- Post menopausal ❑ Yes ❑ No
- Hormone replace therapy ❑ Yes ❑ No
- Dysfunctional uterine bleed ❑ Yes ❑ No
- Endometriosis ❑ Yes ❑ No
- Breast biopsies ❑ Yes ❑ No

Musculoskeletal:
- Fibromyalgia ❑ Yes ❑ No
- Osteoporosis ❑ Yes ❑ No
- Osteoarthritis ❑ Yes ❑ No
- Gout ❑ Yes ❑ No

Integumentary:
- Change in mole ❑ Yes ❑ No
- Change in pigmentation ❑ Yes ❑ No
- Difficulty healing incision ❑ Yes ❑ No
- Keloid ❑ Yes ❑ No
- Melanoma ❑ Yes ❑ No
- Squamous cell cancer ❑ Yes ❑ No
- Basal cell cancer ❑ Yes ❑ No
- Scleroderma ❑ Yes ❑ No
- Lupus ❑ Yes ❑ No
- Psoriasis ❑ Yes ❑ No

Integumentary (cont.):
- Erthema Nodosum ❑ Yes ❑ No
- Herpes Zoster ❑ Yes ❑ No
  - Where: _____
- Post Herpetic Neuralgia ❑ Yes ❑ No

Neurological:
- Light headedness ❑ Yes ❑ No
- Dizziness ❑ Yes ❑ No
- Memory loss ❑ Yes ❑ No
- Tremors ❑ Yes ❑ No
- Imbalance/unsteady gait ❑ Yes ❑ No
- Upper extremity numbness ❑ Yes ❑ No
- Migraine headaches ❑ Yes ❑ No
- Tension headaches ❑ Yes ❑ No
- Concussion ❑ Yes ❑ No
- Seizures ❑ Yes ❑ No
- Multiple Sclerosis ❑ Yes ❑ No
- Bell's Palsy ❑ Yes ❑ No
- Polio ❑ Yes ❑ No
- Post Polio Syndrome ❑ Yes ❑ No
- Muscular Dystrophy ❑ Yes ❑ No
- Pseudotumor Cerebri ❑ Yes ❑ No
- Trigeminal Neuralgia ❑ Yes ❑ No
- Paraplegia ❑ Yes ❑ No
- Hemiplegia ❑ Yes ❑ No

Psychiatric:
- Bi-Polar ❑ Yes ❑ No
- Depression ❑ Yes ❑ No
- Anxiety ❑ Yes ❑ No

Endocrine:
- Pituitary problems ❑ Yes ❑ No
- Thyroid problems ❑ Yes ❑ No
- Adrenal problems ❑ Yes ❑ No

Blood:
- Blue/black discoloration of
  - Fingers ❑ Yes ❑ No
  - Toes ❑ Yes ❑ No
- History excessive bleeding ❑ Yes ❑ No

Diagnosed with:
- Anemia ❑ Yes ❑ No
- Sickle Cell Disease ❑ Yes ❑ No
- Hemophilia ❑ Yes ❑ No
- Christmas Disease ❑ Yes ❑ No
- von Willebrand Disease ❑ Yes ❑ No
- Thrombocytopenia ❑ Yes ❑ No
- Protein C deficiency ❑ Yes ❑ No
- Protein S deficiency ❑ Yes ❑ No
- Factor V Leiden deficiency ❑ Yes ❑ No
- Thrombocytosis ❑ Yes ❑ No
- Polycythemia ❑ Yes ❑ No
- Porphyria ❑ Yes ❑ No
- Hemochromatosis ❑ Yes ❑ No
- Leukemia ❑ Yes ❑ No
- Lymphoma ❑ Yes ❑ No
- Thalassemia Trait A ❑ Yes ❑ No
- Thalassemia Trait B ❑ Yes ❑ No
- Spherocytosis ❑ Yes ❑ No
- HIV positive ❑ Yes ❑ No

Injuries to:
- Head ❑ Yes ❑ No
- Spinal cord ❑ Yes ❑ No
- Neck ❑ Yes ❑ No
- Back ❑ Yes ❑ No
- Chest ❑ Yes ❑ No
- Upper extremity ❑ Yes ❑ No
- Lower extremity ❑ Yes ❑ No
- Abdomen ❑ Yes ❑ No
  - Liver ❑ Yes ❑ No
  - Spleen ❑ Yes ❑ No
  - Kidney ❑ Yes ❑ No
  - Pancreas ❑ Yes ❑ No
  - Stomach ❑ Yes ❑ No
  - Small intestine ❑ Yes ❑ No
  - Large intestine (colon) ❑ Yes ❑ No

ALLERGIES

Are you allergic to any of the following?

Latex: ❑ Yes ❑ No **Surgical Tape**: ❑ Yes ❑ No **X-Ray Dye:** ❑ Yes ❑ No **Iodine**: ❑ Yes ❑ No

Patient Name: _____

► **Please list ALL medications, including over-the-counter (OTC) medications, that you are ALLERGIC to:**

Medications	**Symptoms/Reaction:**
1. _____	❑ Difficulty Breathing ❑ Rash ❑ Nause a ❑ Itching ❑ Other: _____
2. _____	❑ Difficulty Breathing ❑ Rash ❑ Nausea ❑ Itching ❑ Other: _____
3. _____	❑ Difficulty Breathing ❑ Rash ❑ Nausea ❑ Itching ❑ Other: _____
4. _____	❑ Difficulty Breathing ❑ Rash ❑ Nausea ❑ Itching ❑ Other: _____

► **Please list ALL foods/herbs you are ALLERGIC to:**

Foods	**Symptoms/Reaction:**
1. Shellfish ❑ Yes ❑ No	❑ Difficulty Breathing ❑ Rash ❑ Nausea ❑ Itching ❑ Other: _____
2. _____	❑ Difficulty Breathing ❑ Rash ❑ Nausea ❑ Itching ❑ Other: _____
3. _____	❑ Difficulty Breathing ❑ Rash ❑ Nausea ❑ Itching ❑ Other: _____
4. _____	❑ Difficulty Breathing ❑ Rash ❑ Nausea ❑ Itching ❑ Other: _____

CURRENT MEDICATIONS

Please complete for **each** drug and herbal and/or homeopathic medications taken including herbal dietary and weight loss supplements and over the counter medications (such as aspirin). Check medical containers for the correct dosage information.

Name of Medication	Strength	Frequency	Purpose	Start Date	Prescribing Physician

►Have you taken oral steroid pills (ex: Prednisone®) in the last year? ❑ Yes ❑ No
►Are you current with the following immunizations? Tetanus ❑ Yes ❑ No
Hepatitis B ❑ Yes ❑ No
►Are you taking COUMADIN®? ❑ Yes ❑ No
►Are you taking PLAVIX®? ❑ Yes ❑ No
►Have you taken other immunosuppressants? ❑ Yes ❑ No

SURGICAL HISTORY

► **It is important that you complete this for any surgeries you may have had in the past.** We will notify you if there are Operative Reports you will need to obtain from any of these surgeries.

Surgery	Date	Procedure (Open)	Procedure (Laparoscopic)	Surgeon	Reason for Surgery
Brain: Aneurysm					
Brain: Other					
Sinus					
Thyroid					
Thymectomy					
Tonsillectomy/ Adenoidectomy					

Patient Name: _____

Breast					
Cancer (location)					
Eye: Cataract					
Eye: Corneal Transplant					
Eye: Glaucoma					
Neck: Carotid Endarterectomy					
Neck: Fusion					
Lung: Lobectomy					
Lung: Lobectomy					
Chest: Aneurysm					
Heart: Coronary Bypass					
Heart: Valve					
Heart: Pacemaker					
Back: Laminectomy					
Back: Vertebral/Cervical Disc (location)					
Joint replacement (location)					
Varicose veins (Sclerotherapy)					

ABDOMINAL SURGERIES	**DATE**	**Procedure Open**	**Procedure Laparoscopic**	**SURGEON**	**REASON FOR SURGERY**
* Aneurysm: Abdominal aortic					
* Stomach: Ulcer					
* Anti reflux: Nissen Fundoplication					
Colon: Colostomy					
Colon: Other					
* Hernia: Abdominal					
* Gallbladder					
Hysterectomy : Complete (ovaries gone)					
Partial (ovaries remain)					
Oopherectomy: Both Right Left					
Tubal ligation					
C-Sections How many: _____					
Appendectomy					
Bladder Suspension					
Bowel Resection					
Other Abdominal Surgeries					

►**ABDOMINAL SURGERIES NOTE: If you have had any of the surgeries marked with *, you MUST obtain a copy of the Operative Report prior to your final consult.** *Use the "Release of Information Authorization" to have the report sent to our office.*

HISTORY OF RADIATION

Have you had radiation treatment on:

Neck	❑ Yes ❑ No
Breast	❑ Yes ❑ No
Chest	❑ Yes ❑ No
Abdomen	❑ Yes ❑ No
Pelvis	❑ Yes ❑ No

For:

Thyroid Cancer	❑ Yes ❑ No
Hodgkin's Disease	❑ Yes ❑ No
Lymphoma	❑ Yes ❑ No
Breast Cancer	❑ Yes ❑ No
Colon Cancer	❑ Yes ❑ No
Rectal Cancer	❑ Yes ❑ No
Prostrate Cancer	❑ Yes ❑ No

Have you had chemotherapy? ❑ Yes ❑ No

Patient Name: _____

ANESTHESIA SCREEN

Have you ever had anesthesia? ❑ Yes ❑ No

If yes, did you have any of the following:

Nausea and Vomiting	❑ Yes ❑ No	Cardiac Arrythmias	
Airway Difficulty	❑ Yes ❑ No	During Surgery	❑ Yes ❑ No
Narrow Airway	❑ Yes ❑ No	After Surgery	❑ Yes ❑ No
Difficult Intubation	❑ Yes ❑ No	Need for prolonged ventilation	
Fever during surgery	❑ Yes ❑ No	Breathing machine	❑ Yes ❑ No
Difficulty waking up	❑ Yes ❑ No		

Have you ever had problems with:

- Malignant Hyperthermia (MH) ❑ Yes ❑ No
- Pseudocholinesterase Deficiency (prolonged paralysis) ❑ Yes ❑ No
- Neuroleptic Malignant Syndrome ❑ Yes ❑ No

Has a member of your family ever had problems with:

- Malignant Hyperthermia (MH) ❑ Yes ❑ No
- Pseudocholinesterase Deficiency (prolonged paralysis) ❑ Yes ❑ No
- Neuroleptic Malignant Syndrome ❑ Yes ❑ No

Have you ever had an unexplained complication during surgery or anesthesia? ❑ Yes ❑ No

Has a member of your family ever had an unexplained complication? ❑ Yes ❑ No

Do you have Glaucoma? ❑ Yes ❑ No

Have you had a neck injury or neck surgery? ❑ Yes ❑ No

Do you have restricted movement of your neck? ❑ Yes ❑ No

Do you normally wear:

- Contact lenses ❑ Yes ❑ No
- Glasses ❑ Yes ❑ No
- Dentures ❑ Yes ❑ No
- Hearing Aids ❑ Yes ❑ No

Do you have a:

- Beard ❑ Yes ❑ No
- Mustache ❑ Yes ❑ No

Could you be pregnant now? ❑ Yes ❑ No

PAST MEDICAL STUDIES

► **NOTE: If you have had any of the tests marked with an *, you MUST obtain a copy of the Operative Report prior to your final pre-op consult.** Use the "Release of Information Authorization" to have the report sent to our office.

Have you ever had any of the following tests?

	Normal	Abnormal	Date of last test	Reason for test
Breast Biopsy	❑	❑	_____	_____
*EGD	❑	❑	_____	_____
*Cardiac Stress Test	❑	❑	_____	_____
*Cardiac Nuclear Medicine Scan	❑	❑	_____	_____
*Cardiac Catheterization	❑	❑	_____	_____

►**NOTE: If you had an abnormal finding on any of the following three tests, you must obtain a copy of the Operative Report prior to pre-op consult.** Use the Release of Information Authorization to have the report sent to our office.

	Normal	Abnormal	Date of last test	Reason for test
Mammogram	❑	❑	_____	❑ Routine; Other: _____
PAP Smear	❑	❑	_____	❑ Routine; Other: _____
Colonoscopy	❑	❑	_____	❑ Routine; Other: _____

FAMILY HISTORY

Using the letters in parenthesis from the Family Member Chart, please indicate on the line next to the conditions written below which family members have had:

Obesity: _____
Heart Attack: _____
Premature Coronary Artery Disease (PCAD):
PCAD Females Under 65: _____
PCAD Males Under 65: _____
Diabetes: _____
High Cholesterol: _____
Medullary Thyroid Cancer: _____

Breast Cancer: _____
Ovarian Cancer: _____
Colon Cancer: _____
Peptic Ulcer Disease: _____
Adrenal Tumor: _____
Pituitary Tumor: _____
Parathyroid Disease: _____

Family Member Chart
Mother (**M**)
Father (**F**)
Maternal Grandmother (**MGM**)
Maternal Grandfather (**MGF**)
Paternal Grandmother (**PGM**)
Paternal Grandfather (**PGF**)
Brother (**B**)
Sister (**S**)

►**Family History of DVT or PE (Blood Clots)**:
Using the chart above, list family members who you know have had either a Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE): _____

Patient Name: _____

SOCIAL HISTORY

►**Marital Status:** ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Significant Other

If presently married, for how long? _____ Is this your first marriage? ❑ Yes ❑ No If NO, how many previous marriages? _____

On a scale of 1 to 5 (1=least happy), how would you rate your current marriage/relationship? _____

►**Living Circumstance:**

Do you live: ❑ Alone ❑ With parents ❑ With spouse ❑ With significant other ❑ With children ❑ Other: _____

Who is your primary support person? _____ Relationship: _____

►**Education**: What was your last level of schooling? (Please circle)

Grade: 6 7 8 9 10 11 12 College: 1 2 3 4 + Vocational/Trade: ❑

Degrees/Certificates: ❑ A.A. ❑ B.A./B. S. ❑ Master's ❑ Post Graduate ❑ Doctorate ❑ Certificate for _____

►**Employment:** ❑ Working ❑ Unemployed ❑ Unemployed and seeking employment ❑ Disabled ❑ Retired

If employed, how long have you been at this present job? _____

On a scale of 1 to 5 (1=least happy), how happy are you with your present job? _____

►**Tobacco**: Have you used tobacco products in the past? ❑ Yes ❑ No Year Quit: _____
Tobacco used now? ❑ Yes ❑ No

❑ Cigarettes:	Packs per day _____	Number of years _____
❑ Cigars:	Number per day _____	Number of years _____
❑ Pipe:	Times per day _____	Number of years _____
❑ Chew:	Times per day _____	Number of years _____

If you never smoked, how many years were you close to someone who does/did? _____

►**Alcohol**: Do you drink alcohol daily? ❑ Yes ❑ No More than one drink per day? ❑ Yes ❑ No
Drink more than one time daily? ❑ Yes ❑ No

►**Caffeine**: Do you use caffeine, including:

Coffee	❑ Yes ❑ No	How many cups daily?	_____
Soda with caffeine	❑ Yes ❑ No	How many daily?	_____
No-Doz	❑ Yes ❑ No	How often?	_____
Other: _____		How often?	_____

►**Drugs**:

Do you currently use recreational / street drugs? ❑ Yes ❑ No
If no, have you ever in the past? ❑ Yes ❑ No
Have you ever been enrolled in a drug treatment program: ❑ Yes ❑ No If yes, when? _____

►**Activity Level**: (Please check the one level that most accurately describes your activity.)

- ❑ Sedentary (very little exercise)
- ❑ Mild exercise (stairs, walk over three blocks without becoming short of breath, golf)
- ❑ Occasional vigorous exercise (work or recreation – less than 30 minutes/4x a week)
- ❑ Regular vigorous exercise (work or recreation – more than 30 minutes/4x a week)

Do you mow your lawn? ❑ Yes ❑ No Do you climb stairs daily ❑ Yes ❑ No
Is your house on two levels? ❑ Yes ❑ No Do you take daily walks? ❑ Yes ❑ No
Can you push a grocery shopping cart full of goods by yourself? ❑ Yes ❑ No
Do you do aerobics exercise (3 x a week)? ❑ Yes ❑ No
Can you walk up two flights of stairs without getting short of breath or chest pain? ❑ Yes ❑ No
Can you walk three blocks carrying a bag of groceries without getting short of breath or chest pain? ❑ Yes ❑ No

What types of exercise programs have you tried? _____

What prevents you from exercising now? _____

PATIENT STATEMENT:
I have answered the above questions to the best of my ability, and declare that I am not withholding any information which could be detrimental to my health or well-being, or impact the outcome of my medical treatment.

_____ _____
Patient Signature Date