CENTER FOR WEIGHT LOSS SURGERY
34509 9th Avenue S, Suite 103, Federal Way, WA 98003 • 12815 120th Ave NE, Suite J, Kirkland, WA 98034
Phone: 253-815-7774; 425-899-9990 (Toll Free: 877-815-7774) • Fax: 253-815-7708 • www.c4wls.com

Comprehensive Patient History

PERSONAL INFORMATION

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

Address: _____

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

Home Phone: _____ Cell Phone: _____ Work Phone (if ok to contact): _____

Patient Email: _____ Spouse/Partner Name: _____

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 #: _____

Group #: _____ Ins. Phone: _____

SECONDARY Insurance Company: _____

Subscriber Name: _____ Sub. DOB: _____

Subscriber/ID #: _____

Group #: _____ Ins. Phone: _____

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 very 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: _____ *(check our website c4wls.com for instructions)*

Based on your daily experience, please answer the following questions - Has your weight (affected your).				
		Yes	**No**	**Comment (optional)**
1.	Interpersonal relationships: social gatherings, meeting new people; being seen in public; being mistreated, teased or ridiculed; not having friends.	❑	❑	
2.	Attitude, abilities, performance or career at work?	❑	❑	
3.	Daily mobility such as getting dressed, rising from furniture, awkwardness or clumsiness, fastening shoes or clothing, bending over?	❑	❑	
	Are you wheelchair bound?	❑	❑	
	Do you have handicap parking privileges because of weight?	❑	❑	
4	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?	❑	❑	
5.	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.	❑	❑	
6	Ability to find clothes that fit?	❑	❑	
7.	Made it difficult to find chairs/seating in, homes, public transportation?	❑	❑	
8	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	Wellbutrin®	❑ Yes ❑ No
Phentermine (Fastin®)	❑ Yes ❑ No	Pondimin®	❑ Yes ❑ No	Contrave®	❑ Yes ❑ No
Meridia®	❑ Yes ❑ No	Topamax®	❑ Yes ❑ No	Belviq®	❑ Yes ❑ No
Metformin	❑ Yes ❑ No	Byetta®	❑ Yes ❑ No	Saxenda®	❑ Yes ❑ No

Others (include all): _____

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

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

► 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? ❑ Yes ❑ No

Patient Name: _____

► **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
Walk 4 city blocks without stopping?	❑ Yes ❑ No		
If NO, can you walk with cane or crutch?	❑ Yes ❑ No		
Do you use oxygen at home?	❑ Yes ❑ No		
Do you have sleep apnea?	_____	❑ Yes ❑ No	❑ Yes ❑ No
If yes, pressure setting: Using CPAP:	_____	BiPAP: _____	
Snoring disturbs the sleep of others			
❑ Never ❑ Rarely ❑ Occasionally (1-3 times/week) ❑ Frequently (>3 times/week)			
Been told that you pause or stop breathing during sleep			
❑ Never ❑ Rarely ❑ Occasionally (1-3 times/week) ❑ Frequently ((>3 times/week)			
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		
Pulmonary Hypertension	_____	❑ Yes ❑ No	❑ Yes ❑ No

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:	_____	❑ Yes ❑ No	❑ Yes ❑ No
Mitral Valve: ❑ Regurgitation ❑ Prolapse ❑ Stenosis			
Aortic Valve: ❑ Regurgitation ❑ Stenosis			
Heart Failure	_____	❑ Yes ❑ No	❑ Yes ❑ No
Enlarged Heart	_____	❑ Yes ❑ No	❑ Yes ❑ No
Cardiomyopathy	_____	❑ Yes ❑ No	❑ Yes ❑ No
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	
Pacemaker	_____	❑ Yes ❑ No	
Hypertension	_____	❑ Yes ❑ No	❑ Yes ❑ No

NEUROLOGIC	**How Long?**	**Diagnosed?**	**Treatment?**
Stroke	_____	❑ Yes ❑ No	❑ Yes ❑ No
Carotid Artery Disease	_____	❑ Yes ❑ No	❑ Yes ❑ No
TIA-Transient Ischemic Attacks/Blindness	_____	❑ Yes ❑ No	❑ Yes ❑ No

VENOUS THROMBO EMBOLIC DISEASE	**How Long?**	**Diagnosed?**	**Treatment?**
Deep Vein Thrombosis (DVT)	_____	❑ Yes ❑ No	❑ Yes ❑ No
❑ Left leg ❑ Right leg ❑ Both			
Pulmonary Embolism (PE)	_____	❑ 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

STOP-BANG questionnaire

Snoring? ❑ Yes ❑ No
Do you Snore Loudly? (heard through closed doors or wake your bed-partner at night)?

Tired? ❑ Yes ❑ No
Feel **Tired, Fatigued, or Sleepy** during the daytime (i.e. fall asleep driving or talking)?

Observed? ❑ Yes ❑ No
Anyone Observed you Stop Breathing or Choking/Gasping during your sleep?

Pressure? ❑ Yes ❑ No
Have or treated for High Blood Pressure?

BMI > 35kg/m2? ❑ Yes ❑ No

Age > 50 years? ❑ Yes ❑ No

Neck size large? ❑ Yes ❑ No
Male >/= 17"/43cm, Female >/= 16"/41cm?

Gender = Male? ❑ Yes ❑ No

Patient Name: _____

ENDOCRINE	**How Long?**	**Diagnosed?**	**Treatment?**
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
Elevated Cholesterol	_____	❑ Yes ❑ No	❑ Yes ❑ No
Elevated Triglycerides	_____	❑ Yes ❑ No	❑ Yes ❑ No
Hypothyroidism	_____	❑ Yes ❑ No	❑ Yes ❑ No

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

MUSCULOSKELETAL

Arthritis		❑ Yes ❑ No
Low back pain		❑ Yes ❑ No
Pain down to leg ❑ Left ❑ Right ❑ Both		❑ Yes ❑ No
Joint replacement:		
Hips: ❑ Left ❑ Right ❑ Both		❑ Yes ❑ No
Knees: ❑ Left ❑ Right ❑ Both		❑ Yes ❑ No
Pain/numbness/tingling in:		
Hips: ❑ Left ❑ Right ❑ Both		❑ Yes ❑ No
Knees: ❑ Left ❑ Right ❑ Both		❑ Yes ❑ No
Ankles: ❑ Left ❑ Right ❑ Both		❑ Yes ❑ No
Feet: ❑ Left ❑ Right ❑ Both		❑ Yes ❑ No
Carpal Tunnel: ❑ Left ❑ Right ❑ Both		❑ Yes ❑ No

GENITOURINARY

Urinary stress incontinence	❑ Yes ❑ No
Polycystic Ovarian Syndrome	❑ Yes ❑ No
Infertility	❑ Yes ❑ No

PSYCHOLOGICAL

Depression	❑ Yes ❑ No

SKIN

Hirsutism (excessive facial hair)	❑ Yes ❑ No
Intertrigenous Dermatitis	❑ Yes ❑ No
(Rash under breasts, abdominal folds, groin)	
Loose hanging skin	❑ Yes ❑ No
Where? ❑ Abdomen ❑ Arms ❑ Thighs	

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**	**Laparoscopic**	**Open**	**Surgeon**	**Facility/ Location**
Sleeve Gastrectomy					
Adjustable Gastric Band					
Gastric Bypass:					
Distal Bypass					
Medial Bypass					
Proximal Bypass					
Duodenal Switch (DS)					
DS- Single anastomosis (DS-SA, SIPS, SADI)					
Vertical Banded Gastroplasty					
Other					
Comments:					

Patient Name: _____

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 movement ❑ Yes ❑ No

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

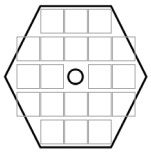
Ears:
Ear pain ❑ Yes ❑ No
Ear infections ❑ Yes ❑ No
Excessive discharge ❑ Yes ❑ No
Hearing problems ❑ Yes ❑ No
Acoustic Neuroma ❑ Yes ❑ No
Benign Positional Vertigo ❑ Yes ❑ No

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
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 (>3 ❑ Yes ❑ No
months) Lung Cancer ❑ Yes ❑ No
Peripheral Vascular Disease ❑ Yes ❑ No
Sarcoidosis ❑ Yes ❑ No
Mesothelioma ❑ Yes ❑ No
COPD (Chronic Obstructive ❑ Yes ❑ No
Pulmonary Disorder)
Emphysema ❑ Yes ❑ No
Tuberculosis ❑ Yes ❑ No
Histoplasmosis ❑ Yes ❑ No
Covid-19 ❑ Yes ❑ No

Gastrointestinal:
Voice hoarse ❑ Yes ❑ No
Cough at night ❑ Yes ❑ No
Abdominal pain ❑ Yes ❑ No
Type of pain: ❑ Yes ❑ No
Sharp ❑ Yes ❑ No
Dull ❑ Yes ❑ No
Hot ❑ Yes ❑ No
Cold ❑ Yes ❑ No
Aching ❑ Yes ❑ No
Crushing ❑ Yes ❑ No
Indicate where:



When does pain begin?
Before eating ❑ Yes ❑ No
During eating ❑ Yes ❑ No
After eating ❑ Yes ❑ No
Frequency:
1-2 times/week ❑ Yes ❑ No
8+ times/week ❑ Yes ❑ No
Trouble swallowing: ❑ Yes ❑ No
Liquids ❑ Yes ❑ No
Solids ❑ Yes ❑ No
Nausea ❑ Yes ❑ No
Vomiting ❑ 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

Liver Disease
Hepatitis B ❑ Yes ❑ No
Hepatitis C ❑ Yes ❑ No
Cirrhosis ❑ Yes ❑ No
Steato Hepatitis ❑ Yes ❑ No
Non-Alcoholic ❑ Yes ❑ No
Steato Hepatitis (NASH)
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
Erthema Nodosum ❑ Yes ❑ No
Herpes Zoster ❑ Yes ❑ No
Where: _____
Post Herpetic Neuralgia ❑ Yes ❑ No

Patient Name: _____

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 ❑ Yes ❑ No
Fingers ❑ Yes ❑ No
Toes ❑ Yes ❑ No
History excessive bleeding ❑ Yes ❑ No
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
Other/Comment

ALLERGIES

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

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

Medications	**Symptoms/Reaction:**
1. _____	❑ 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: _____

► 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: _____

Patient Name: _____

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. Please use the overflow section at the end if you need more space.

Name of Medication	Strength	Frequency	Purpose	Start Date	Prescribing Physician

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

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					
* Bowel Resection					
* Gallbladder					
Hysterectomy : Complete (ovaries gone)					
Partial (ovaries remain)					
Oopherectomy: ❑ Left ❑ Right ❑ Both					
Tubal ligation					
C-Sections How many: _____					
Appendectomy					
Bladder Suspension					
Other Abdominal Surgeries					
Tummy Tuck (abdominoplasty)					
Other Cosmetic Surgeries: ❑ Thighs ❑ Buttocks ❑ Arms					
Cosmetic Breast Surgery: ❑ Augmentation ❑ Lift					

►**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.*

Patient Name: _____

Surgery	Date	Surgeon	Reason for Surgery
Brain: Aneurysm			
Brain: Other			
Sinus			
Thyroid			
Thymectomy			
Tonsil/ Adenoidectomy			
Breast Cancer (location)			
Eye: Cataract			
Eye: Corneal Transplant			
Eye: Glaucoma			
Carotid Endarterectomy			
Neck: Fusion			
Lung: Lobectomy			
Chest: Aneurysm			
Heart: Coronary Bypass			
Heart: Valve			
Heart: Pacemaker			
Back: Laminectomy			
Back: Vertebral/Cervical Disc (location)			
Joint replacement (location)			
Varicose veins (Sclerotherapy)			

HISTORY OF RADIATION

Have you had radiation treatment on:

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

Have you had chemotherapy? ❑ 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

ANESTHESIA SCREEN

Have you ever had anesthesia? ❑ Yes ❑ No

If yes, did you have any of the following:

- Nausea and Vomiting ❑ Yes ❑ No
- Airway Difficulty ❑ Yes ❑ No
- Narrow Airway ❑ Yes ❑ No
- Difficult Intubation ❑ Yes ❑ No
- Fever during surgery ❑ Yes ❑ No
- Difficulty waking up ❑ Yes ❑ No

Cardiac Arrythmias

- During Surgery ❑ Yes ❑ No
- After Surgery ❑ Yes ❑ No

Need for prolonged ventilation

- Breathing machine ❑ 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 had an <u>unexplained complication</u> during surgery/ anesthesia? ❑ Yes ❑ No
Has a member of your family ever had an <u>unexplained complication</u>? ❑ 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

Patient Name: _____

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 <u>abnormal finding</u> 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 <u>letters in parenthesis</u> 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 55: _____
Diabetes: _____
High Cholesterol: _____
Breast Cancer: _____
Ovarian Cancer: _____
Colon Cancer: _____
Peptic Ulcer Disease: _____
Adrenal Tumor: _____
Pituitary Tumor: _____
Parathyroid Disease: _____
Thyroid Cancer: _____

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 list family members who you know have had either a Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE):
_____

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? _____

Patient Name: _____

►**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

What types of exercise programs have you tried? _____

What prevents you from exercising now? _____

►**METS Check**:
Can you walk up two flights of stairs without getting short of breath or chest pain? ❑ Yes ❑ No
Can you walk at least 4 city blocks (0.4 miles or 7 times the length of a football field) carrying a bag of groceries without getting short of breath or chest pain? ❑ Yes ❑ No

Other

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