Last Name:

Patient Profile

Personal Information			
Last Name:	First Name		
Phone Number:	Spouse's/Significant Other's Name:		
Date of Birth:	Height:	Weight:	BMI:

Referral Information	
How did you hear about us? Please check all that apply. _____ Physician _____Other patient _____Newspaper _____Internet _____ Television _____ E-mail Other:	
Referring Doctor:	Date of referral:
Telephone #:	Fax #:

Contact Person(s)	
This information is vital to us if we need to contact you urgently. Occasionally people move or have new phone numbers and do not update our office. Next of KIN (not living with you)	
Name:	Relationship:
Address: Telephone (home):	(work):
Occasionally it is beneficial to you for us to discuss your confidential information such as spouse, partner, family member, etc. (initial one below) _____ I do not authorize Dr. Berger or Dr. Aldridge to discuss my confidential information with anyone _____ I authorize Dr. Berger or Dr. Aldridge to discuss my confidential information with:	
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Your Signature:	

Social History
Support person(s):
How do the people around you feel about you considering surgery?
Employment
Are you currently employed? Yes_____ No_____ If you are unemployed, how long?
Reason: _____ Physically unable to work _____ Emotionally unstable to work _____ Feeling that appearance is inappropriate for job sought Other:
Are you currently disabled or on disability? Yes_____ No_____ If so, for how long?
Do you enjoy your work? Yes_____ No_____

Physicians	
Primary Care Physician:	Phone #
Cardiologist (Heart):	Phone #
Psychologist:	Phone #
Pulmonologist (Lungs):	Phone #
Gastroenterologist (GI doctor):	Phone #
Orthopedic Surgeon:	Phone #
Endocrinologist:	Phone #
Other:	Phone #

Allergies **_____ NO KNOWN ALLERGIES**

Drug	**If allergic, please check**	**Indicate Reaction**
Aspirin		
Codeine		
Iodine		
Keflex		
Penicillin		
Sulfa		
Other medications		
Other:	**If allergic, please check**	**Indicate Reaction**
Anesthesia		
Tape		
Heparin		
Latex		
Food		
Other allergies:		

Last name:

Detailed Diet History

Fill in the dates you participated in the following diet programs, as well as how much weight loss, and the amount regained after stopping the program.

Program	# of Months	Pounds Lost	Pounds Regained
Atkins			
Cabbage Diet			
Calorie Counting			
Dexatrim			
Diet Center			
Exercise Program			
Grapefruit Diet			
Herbal Diets			
Jenny Craig			
Ketogenic Diet			
Low Fat			
Nutrisystem			
Optifast			
Overeaters Anon.			
Richard Simmons			
Slim Fast			
TOPS			
Weight Watchers			
Other:			

Medication	# of Months	Pounds Lost	Pounds Gained
Fastin			
Phenteramine/Fenfluramine			
Other:			

Past Medical History

Head and Neck	_____ Glaucoma _____ Cataracts _____Hearing Loss _____ Vertigo _____ Tinnitus _____Migraine Headaches Other:
Cardiovascular	_____ High blood pressure _____ Irregular heartbeat _____ Congestive heart failure _____ Coronary artery disease _____ Heart valve problems/murmur _____ High cholesterol/lipids Otherr:_____
Pulmonary	_____ Pulmonary hypertension _____Right heart failure _____ Obstructive sleep apnea _____ Chronic obstructive pulmonary disease (COPD) _____ Emphysema _____ Asthma _____ Childhood asthma, resolved _____Pulmonary embolus Other:
Gastrointestinal	_____ Gastroesophageal reflux (GERD) _____Ulcers Type: _____ _____ Diverticulosis _____ Diverticulitis _____ Gallstones _____ Non-Alcoholic Steatohepatitis (NASH) _____ Cirrhosis _____ Portal hypertension _____ Pancreatitis _____Adhesive bowel disease Other: _____

Genitourinary	_____ Kidney stones _____ Urinary incontinence _____ Kidney failure _____ Urinary tract infection _____ Kidney infection _____Gout Other:
Gynecologic	_____ Excessively heavy periods (Menorrhagia) _____ Infertility _____ Polycystic Ovary Disease Other: _____
Endocrine	_____ Diabetes _____ Hypothyroidism _____ Hyperthyroidism _____ Goiter _____ Graves disease Other: _____
Neurologic	_____ Stroke _____ Seizure disorder _____ Epilepsy _____ Carotid artery disease Other:
Blood	_____ Anemia _____ Deep venous thrombosis (Blood clots) _____ Low platelets (Thrombocytopenia) Other:_____
Psychologic	_____ Anxiety disorder _____ Depression _____ Bi-polar disorder _____ Schizophrenia _____ Anorexia _____ Bulimia Other: _____
Musculoskeletal	_____ Rheumatoid arthritis _____ Osteoarthritis (Degenerative joint disease) _____ Plantar fasciitis Other:
Infectious Disease	_____ HIV positive _____ Hepatitis (circle any that apply: A B C Other:_____) Other:
Substance Abuse	___ Intravenous drugs ___ Tobacco ___ Alcoholism ___ Marijuana ___ CBD Other: _____ <u>If applicable:</u> Specifically describe the number of drinks per day, week OR month: _____per_____ Specifically describe the number of cigarettes per day, week OR month: _____per_____ Specifically describe the number of cigars per day, week OR month: _____per_____ Have you had a problem with substance addiction? _____Yes _____No If so, _____ Drugs _____ Alcohol _____ Tobacco Other_____ If yes, how long ago did you quit? _____months _____years What treatment did you receive? _____ None _____ outpatient counseling _____Inpatient counseling _____ Support groups (e.g. AA)

Past Surgical History

Please indicate with a check any of the following surgeries you have had and the year preformed.

Type of surgery	Had surgery	Laparoscopic or open	Year
<u>Abdominal/Pelvic</u>			
Appendectomy			
Cesarean Section			
Gallbladder			
Gastric Bypass			
Gastric Band			
Hernia repair, abdominal Mesh? Y N			
Hernia repair, umbilical Mesh? Y N			
Hernia repair, inguinal			
Hysterectomy			
Liposuction			

Type of Surgery	Had surgery	Laparoscopic or open	Year
Ovarian cystectomy			
Panniculectomy			
Prostate Surgery			
Tubal ligation			
Vertical Banded Gastroplasty			
Orthopedic/Spine			
Ankle Surgery			
Back Surgery			
Knee Surgery			
Lumbar Laminectomy			
Lumbar Fusion			
Other			
Adenoidectomy/Tonsillectomy			
Breast Surgery			
Carpal Tunnel Surgery			
Coronary Bypass (heart)			
Other Heart Surgery (e.g. valve)			
Eye Surgery			
Oral Surgery			
Pilonidal Cystectomy			
Wisdom Teeth			
Other:			

Any problems with anesthesia? _____Yes _____No Describe:

Medications

Please list all the prescription medications you are currently taking. Please use the information from the prescription label.

Name of Medication	Dose (mg, units, etc.)	Frequency (e.g. once per day)	Used for:

Please list all herbal supplements, over the counter drugs, vitamins, etc. Include any medications recently stopped (within 6 months). Specifically address any use of aspirin, coumadin, lovenox, ibuprofen, garlic, vitamin E.

Name	Dose (mg, units, etc.)	How often used	Last time used

Family History

Please describe you family medical history:

Father: _____ Living _____Deceased

If deceased, what age and cause:

Mother: _____ Living _____Deceased

If deceased, what age and cause:

Brother(s): _____ # Living _____# Deceased

If deceased, what age(s) and cause(s):

Sister(s): _____ # Living _____# Deceased

If deceased, what age(s) and cause(s):

Check all that apply:

Relationship	Obesity	Diabetes (If yes, what type)	Heart Disease	High Blood Pressure	Cancer (If yes, what type)
Father					
Mother					
Brother(s)					
Sister(s)					
Children					

Any family history of problems with anesthesia? _____Yes _____No

If so, what is the problem?

Any family history of bleeding or bruising? _____Yes _____No

Last name:

Personal Medical Information: Check all that apply:

Head and Neck	Yes	No
Do you wear glasses?		
Do you wear contacts?		
Do you have regular dental checkups?		
Have you had previous dental surgery?		
Do you have missing teeth? If yes, do you wear dentures? _____Yes _____No		

Cardiac

Have you ever had:	Yes (If yes, abnormal or need further testing?)	No
Electrocardiogram (EKG)		
Echocardiogram		
Stress test		
Cardia Catheterization		
Heart attack		
Chest pain	Describe:	
Heart palpitations		
Ankle Swelling		
Varicose Veins		
Leg Ulcers		
Irregular heartbeats		
Shortness of breath WITH exertion		

Pulmonary

Have you ever been hospitalized for a pulmonary problem? _____ Yes _____No

What problem? Date(s)?
ICU? _____Yes _____No On a ventilator (breathing machine)? _____Yes _____No
Have you used steroids for a lung problem? _____Yes _____No If yes, short or long term steroids? _____
How well rested do you feel after a full night's sleep? _____Not at all_____Somewhat _____Well rested

Check all that apply:	**Yes**	**No**
Snorting or gasping during sleep		
Loud snoring		
Breathing stops/Choke or struggle for breath		
Frequent awakenings		
Tossing, turning or thrashing		
Difficulty falling asleep		
Morning headaches		

Check all that apply:	Yes	No
Night sweats		
More than two pillows under head		
Falling asleep at work or school		
Falling asleep while driving		
Excessive daytime drowsiness		
Awaken feeling paralyzed, unable to move		
Wheezing		
Coughing		

Gastrointestinal/ GERD (Gastroesophageal Reflux Disease)

How often do you have reflux (Heartburn/regurgitation)? _____Many times per day _____Once per day

_____Most days _____Most weeks _____Infrequent

Do you suffer from heartburn/indigestion during the night? _____Yes _____No

_____Many times per night _____Once per night _____Most nights _____Most weeks

_____Infrequent

Treatments that you may use for reflux, heartburn or indigestion:

Check all that apply: _____Zantac _____Tagamet _____Pepcid _____Prevacid

_____Nexium _____Prilosec _____Surgery

Check all that apply:	Yes	No
Does food or acidic fluid reflux in the mouth?		
Do you vomit with reflux?		
Do you have frequent loose stool/diarrhea?		
Chronic constipation?		
Abdominal pain after meals?		
Frequent bloating?		

Does food or acidic fluid reflux in the mouth? _____Yes _____No Do you vomit with reflux? _____Yes _____No

Do you have frequent diarrhea? _____Yes _____No Chronic constipation? _____Yes _____No

Genitourinary

Check all that apply:	Yes	No
Stress incontinence		
Urinary frequency		
Frequent urinary tract infections		
Vaginal discharge		
Irregular periods		
Excessively painful periods		
Excess body hair or acne		
Difficulty in conceiving		
Birth control pills		
Are you planning a pregnancy in the next 2 years?		

Endocrine

Have you been diagnosed with thyroid disease? _____Yes	_____No	If so, what type:
Have you been diagnosed or treated for diabetes? _____Yes Year diagnosed:_____ Year diagnosed:_____	_____No	If so, check all that apply: _____Juvenile Onset _____Adult Onset
Current form of control (check all that apply):		
_____Diet		As of (year) _____
_____Oral medication		As of (year) _____
_____Insulin injections (Average # of injections/ day: _____)		As of (year) _____
Have you had Hemoglobin A1C levels tested (glycosylated hemoglobin)? _____Yes _____No		If yes, what level?