

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.	
<input type="checkbox"/> Physician <input type="checkbox"/> Other patient <input type="checkbox"/> Television <input type="checkbox"/> E-mail	<input type="checkbox"/> Newspaper <input type="checkbox"/> Internet 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)	
<input type="checkbox"/> I do not authorize Dr. Berger or Dr. Aldridge to discuss my confidential information with anyone	
<input type="checkbox"/> 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	<input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataracts <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Vertigo <input type="checkbox"/> Tinnitus <input type="checkbox"/> Migraine Headaches Other: _____
Cardiovascular	<input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heartbeat <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Coronary artery disease <input type="checkbox"/> Heart valve problems/murmur <input type="checkbox"/> High cholesterol/lipids Other: _____
Pulmonary	<input type="checkbox"/> Pulmonary hypertension <input type="checkbox"/> Right heart failure <input type="checkbox"/> Obstructive sleep apnea <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD) <input type="checkbox"/> Emphysema <input type="checkbox"/> Asthma <input type="checkbox"/> Childhood asthma, resolved <input type="checkbox"/> Pulmonary embolus Other: _____
Gastrointestinal	<input type="checkbox"/> Gastroesophageal reflux (GERD) <input type="checkbox"/> Ulcers Type: _____ <input type="checkbox"/> Diverticulosis <input type="checkbox"/> Diverticulitis <input type="checkbox"/> Gallstones <input type="checkbox"/> Non-Alcoholic Steatohepatitis (NASH) <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Portal hypertension <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Adhesive bowel disease Other: _____

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Genitourinary	<input type="checkbox"/> Kidney stones <input type="checkbox"/> Urinary incontinence <input type="checkbox"/> Kidney failure <input type="checkbox"/> Urinary tract infection <input type="checkbox"/> Kidney infection <input type="checkbox"/> Gout Other: _____
Gynecologic	<input type="checkbox"/> Excessively heavy periods (Menorrhagia) <input type="checkbox"/> Infertility <input type="checkbox"/> Polycystic Ovary Disease Other: _____
Endocrine	<input type="checkbox"/> Diabetes <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Goiter <input type="checkbox"/> Graves disease Other: _____
Neurologic	<input type="checkbox"/> Stroke <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Epilepsy <input type="checkbox"/> Carotid artery disease Other: _____
Blood	<input type="checkbox"/> Anemia <input type="checkbox"/> Deep venous thrombosis (Blood clots) <input type="checkbox"/> Low platelets (Thrombocytopenia) Other: _____
Psychologic	<input type="checkbox"/> Anxiety disorder <input type="checkbox"/> Depression <input type="checkbox"/> Bi-polar disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Anorexia <input type="checkbox"/> Bulimia Other: _____
Musculoskeletal	<input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Osteoarthritis (Degenerative joint disease) <input type="checkbox"/> Plantar fasciitis Other: _____
Infectious Disease	<input type="checkbox"/> HIV positive <input type="checkbox"/> Hepatitis (circle any that apply: A B C Other: _____) Other: _____
Substance Abuse	<input type="checkbox"/> Intravenous drugs <input type="checkbox"/> Tobacco <input type="checkbox"/> Alcoholism <input type="checkbox"/> Marijuana <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, <input type="checkbox"/> Drugs <input type="checkbox"/> Alcohol <input type="checkbox"/> Tobacco Other _____ If yes, how long ago did you quit? _____ months _____ years What treatment did you receive? <input type="checkbox"/> None <input type="checkbox"/> outpatient counseling <input type="checkbox"/> Inpatient counseling <input type="checkbox"/> Support groups (e.g. AA)

Past Surgical History

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

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			

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Type of Surgery	Had surgery	Laparoscopic or open	Year
Ovarian cystectomy			
Panniculectomy			
Prostate Surgery			
Tubal ligation			
Vertical Banded Gastropasty			
<u>Orthopedic/Spine</u>			
Ankle Surgery			
Back Surgery			
Knee Surgery			
Lumbar Laminectomy			
Lumbar Fusion			
<u>Other</u>			
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:

Last name:

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

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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		

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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?		

Last name:

Endocrine

Have you been diagnosed with thyroid disease? ____ Yes ____ No		If so, what type:
Have you been diagnosed or treated for diabetes? ____ Yes ____ No		If so, check all that apply: ____ Juvenile Onset ____ Adult Onset
Year diagnosed: _____ Year diagnosed: _____		
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?