

# MEDICAL AND PATIENT INFORMATION QUESTIONNAIRE (DOC-01)

Date:

Patient Inform	nation				
First Name:		Last Name			
Date of Birth:	Age:	Sex:	(M or F)	Race:	
Mailing Addre	ess:				
City:	State:	Zip:			
Social Security	<i>/</i> :				
	Contact Inform	nation	Best w	ay to contact (Ch	neck all that apply)
Home Phone	2				
Work Phone					
Cell Phone					
Email					
Single       Married       Domestic Partner       Divorced       Widowed Years         Spouse or Significant Other's Name:         Children:       Yes       No       Ages         Education:       High School       Some College       College Graduate         Graduate Degree       Professional Degree					
Pharmacy:					
Name:					
Address:					
City:	State:	Zip:			
Phone numbe	er:	Fax number:			
<u>Employment</u>					

Occupation:	Employer:	
Employer Address:		
Work Phone:	May we contact you at work?	(Yes/No)

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#### **Emergency Contact Information**

Name:		Relationship:	
Home Phone:		Work Phone:	Cell Phone:
Address:			
City:	State:	Zip:	

## **Referring or Primary Care Physician**

Name:

Phone: Fax:

Address:

City: State: Zip:

Have your discussed weight loss surgery with your Physician? (Yes/No)

Exams	Last Date	9
Complete physical exam		
Lab Work (Blood Test)		
Chest X-Ray / EKG	/	
Female Patients On	ly	
Age of first period:	Regular: (Yes/No	o)
Date of last Menstrual Cycle		
Number of pregnancies past first trimester / Live birth	/	

## **Social Habits**

	Ever used	How much	Since (date)	If stopped when (date)
Smoking	(Yes/No)			
Other tobacco	(Yes/No)			
Alcohol	(Yes/No)			
Other drugs (specify)				

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## Weight Loss Programs You Have Tried

Jenny Craig	Atkins	Acupuncture
🗌 MediFast/ OptiFast	🗌 Nutrisystem	🗌 Phen Fen
🗌 Slim Fast	Weight Watchers	🗌 Xenical
🗌 Metabolife	🗌 Meridia	🗌 Redux

Other Programs:

Can you provide the records or receipts for any of the above programs: (Yes/No)

## **Height /Weight information**

Provide the best estimate	Height	Weight
Height/Weight in Jr. High School		
Height/Weight in High School		
Lowest weight as an adult		
Highest weight as an adult		
Your Last known		

Family members >50 lbs over weight

#### **Allergies**

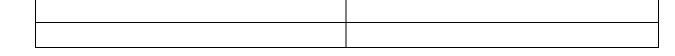
Medication or Food	Symptoms (Nausea, shortness of breath etc)

## Medications (may attach a list if available)

Name	Dosage and frequency



Tel: 818-812-7222 Fax: 818-952-0990 General Surgery Weight Loss Surgery Advanced Laparoscopic Surgery Robotic Surgery



#### **Previous Surgeries**

Operation (including C-section)	Date

### **Past Medical problems**

Check all that apply (Diagnostic codes are for internal use)

Cardiovascular	<u>Musculoskeletal</u>	
<ul> <li>Arrhythmia -Irregular heart rhythm I49.9</li> <li>History of Heart Attack Z86.74</li> <li>High Blood Pressure (HTN) I10</li> <li>Congestive heart failure (CHF) I50.9</li> <li>Venous insufficiency (peripheral) I87.2</li> <li>Swelling of ankles M25.473</li> </ul>	<ul> <li>Arthritis – weight bearing joints M12.9</li> <li>Joint pain – weight bearing joints M25.50</li> <li>Joint pain – Back M25.50</li> <li>Joint pain – Foot M25.579</li> <li>Joint pain – Hip M25.559</li> <li>Joint pain – Knee M25.569</li> </ul>	
Gastrointestinal	Neuro-Psycho-Social conditions-stressors	
Difficulty swallowing R13.10 Reflux Disease (GERD) K21.9 Heartburn R12 Cholelithiasis -Gall stones K80.20 Fatty liver K76.0	<ul> <li>Anxiety disorder F41.9</li> <li>Bipolar disorder F31.9</li> <li>Depression F32.9</li> <li>History of alcohol abuse Z65.8</li> <li>Panic disorder F41.0</li> <li>Pseudotumor Cerebri G93.2</li> </ul>	
<ul> <li>Diabetes Mellitus type II E11.9</li> <li>Hypothyroidism E03.9</li> <li>Hyperlipidemia E79.0</li> <li>Low Calcium - Hypocalcemia E83.51</li> <li>Hyperparathyroidism E21.3</li> <li>Hypoglycemia, unspecified 251.2</li> </ul>	General complaints and Complications of previous WLS (if any) Abdominal pain R10.09 Anemia D64.9 Anorexia (loss of appetite) R63.0 Bezoar Obstruction – Food blockage	

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Ara Keshishian, MD, FACS, FASMBS A Professional Medical Corporation 10 Congress St., Suite #300 Pasadena, CA 91105-3027 Tel : 818-812-7222 Fax : 818-952-0990	General Surgery Weight Loss Surgery Advanced Laparoscopic Surgery Robotic Surgery
Respiratory System         Asthma – unspecified J45.909         Snoring R06.83         Snort or gasp- at night – wakes you up R06.89         Obstructive sleep apnea G47.33         Unspecified sleep apnea G47.30         Urinary         Frequent urination R35.0         Urinary stress incontinence – Female N39.3         Urinary stress incontinence – Male N39.3         Urinary stress incontinence – Male N39.3         Gynecological         Heavy periods N92.0         Amenorrhea (no periods) N91.2         Infertility N92.6         Irregular periods N92.6         Dysmenorrhea – Painful periods N94.6         Polycystic ovary disease E28.2	R18.2XXA Dumping syndrome K91.1 Hair loss L65.9 Nausea R11.0 Protein-calorie malnutrition E46 Pulmonary Embolism – post operative I26.99 Others not listed (write in please):

## **Miscellaneous Information**

Do you take Vitamins	? (Yes/No)	Daily?	(Yes/No)
Do you smoke?	(Yes/No) Nu	umber of packs:	Number of years:
Quit? (Yes/No)	When?		
Do you drink any alco	holic beverages:	(Yes/No)	If yes, type?
Do you or have you us	sed any illicit drug	s: (Yes/No)	If yes, ttype:
How Long:	When was the las	st time you used:	

Do you live alone:(Yes/No)Do you care for young children or any elderly:(Yes/No)List household members (Names & ages):(Yes/No)

The information completed in this packet is true and correct to the best of my belief

Print your name: Date:

Signature: