

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

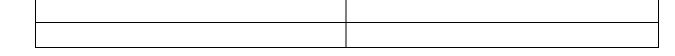
Medication or Food	Symptoms (Nausea, shortness of breath etc)

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>	
 Arrhythmia -Irregular heart rhythm I49.9 History of Heart Attack Z86.74 High Blood Pressure (HTN) I10 Congestive heart failure (CHF) I50.9 Venous insufficiency (peripheral) I87.2 Swelling of ankles M25.473 	 Arthritis – weight bearing joints M12.9 Joint pain – weight bearing joints M25.50 Joint pain – Back M25.50 Joint pain – Foot M25.579 Joint pain – Hip M25.559 Joint pain – Knee M25.569 	
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	 Anxiety disorder F41.9 Bipolar disorder F31.9 Depression F32.9 History of alcohol abuse Z65.8 Panic disorder F41.0 Pseudotumor Cerebri G93.2 	
 Diabetes Mellitus type II E11.9 Hypothyroidism E03.9 Hyperlipidemia E79.0 Low Calcium - Hypocalcemia E83.51 Hyperparathyroidism E21.3 Hypoglycemia, unspecified 251.2 	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: