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

MEDICAL AND PATIENT INFORMATION QUESTIONNAIRE (DOC-01)

Date:

Patient Information

First Name: Last Name:

Date of Birth: Age: Sex: (M or F) Race:

Mailing Address:

City: State: Zip:

Social Security:

Contact Information	**Best way to contact** (Check all that apply)
Home Phone	☐
Work Phone	☐
Cell Phone	☐
Email	☐

Marital Status:

☐ 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 number: Fax number:

Employment

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
Complete physical exam	
Lab Work (Blood Test)	
Chest X-Ray / EKG	/
Female Patients Only	
Age of first period:	Regular: (Yes/No)
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

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Previous Surgeries

Operation (including C-section)	Date

Past Medical problems

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

Cardiovascular

- ☐ 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

Musculoskeletal

- ☐ 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

- ☐ Difficulty swallowing R13.10
- ☐ Reflux Disease (GERD) K21.9
- ☐ Heartburn R12
- ☐ Cholelithiasis -Gall stones K80.20
- ☐ Fatty liver K76.0

Neuro-Psycho-Social conditions-stressors

- ☐ 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

Endocrine

- ☐ 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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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

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) Number of packs: Number of years:
Quit? (Yes/No) When?
Do you drink any alcoholic beverages: (Yes/No) If yes, type?
Do you or have you used any illicit drugs: (Yes/No) If yes, ttype:
How Long: When was the last 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):

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

Print your name: Date:

Signature: