Ara Keshishian, MD, FACS, FASMBS
A Professional Medical Corporation
10 Congress St., Suite #405
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 ☐ F Race: _____

Mailing Address: _____

City: _____State: _____ Zip:_____ Social Security: _____

Contact information		Best way to contact you (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

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship:_____

Home Phone: (_____) _____ -_____ Work Phone: (_____) _____ -_____

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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

Date of Last		
Complete physical exam	____/____/_____	
Lab Work (Blood Test)	____/____/_____	
Chest X-Ray / EKG	____/____/_____	____/____/_____
Pap Smear/ Mammogram	____/____/_____	____/____/_____
	____/____/_____	
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)			____/_____	____/_____

Weight Loss Programs You Have Tried

Jenny Craig	☐	Atkins	☐	Acupuncture	☐

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MediFast/ OptiFast	☐	Nutrisystem	☐	Phen Fen	☐
Slim Fast	☐	Weight Watchers	☐	Xenical	☐
Metabolife	☐	Meridia	☐	Redux	☐

Other	

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

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

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

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

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

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 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 Type:
How Long:_____ When was the last time you used: _____

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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: _____