Advanced Laparoscopic Specialists

Minimally Invasive and Bariatric Surgery

Health Questionnaire (*Please Print)*

Date of Visit: _____

Name: _____ _____ _____

Last First MI

Date of Birth:_____ Social Security #_____

Driver's License #: _____ State_____

Address: _____

City: _____ State_____ ZIP_____

Home Phone: _____ Mobile Phone_____

E-mail: _____

Occupation:_____

Employer: _____ Address: _____

Phone: _____ _____

Emergency Contact

Name _____ Relationship _____

Address_____ Phone_____

Health Insurance

Principal Insurance Holder: □ Self □ Spouse □ Partner

Name of Primary Health Insurance	Subscriber/Group ID	Policy #
If you are ***not*** the primary subscriber: Name of Insured:	Insured's Social Security #:	Insured'sDate of Birth
Other Health Insurance	Subscriber/Group ID	

Which physicians would you like us to contact regarding your treatment here?

Who referred you to our practice?	
Primary Physician	Address/Phone
Cardiologist	Address/Phone
Pulmonologist	Address/Phone
Gastroenterologist	Address/Phone
Preferred Pharmacy	Address/Phone

Medical History

Review of Systems

Do you currently have or have you in the past had any of the following?

- ☐ Yes ☐ No Weight Loss
- ☐ Yes ☐ No Shaking/Chills
- ☐ Yes ☐ No Abdominal pain
- ☐ Yes ☐ No Vomiting
- ☐ Yes ☐ No Difficulty swallowing
- ☐ Yes ☐ No Bleeding per rectum
- ☐ Yes ☐ No Difficult/painful urination
- ☐ Yes ☐ No Previous abdominal surgery
- ☐ Yes ☐ No Previous heart surgery
- ☐ Yes ☐ No Kidney problems
- ☐ Yes ☐ No Previous lung surgery (prednisone, etc?)
- ☐ Yes ☐ No Previous organ transplant
- ☐ Yes ☐ No Cancer
- ☐ Yes ☐ No High blood pressure
- ☐ Yes ☐ No Heart attack or heart disease (congestive heart failure)
- ☐ Yes ☐ No Emphysema, Asthma or lung disease
- ☐ Yes ☐ No Blood clots in legs
- ☐ Yes ☐ No Have you ever taken a blood thinner like Coumadin (warfarin) or Heparin?
- ☐ Yes ☐ No Liver disease, cirrhosis, or hepatitis
- ☐ Yes ☐ No Disease of the pancreas
- ☐ Yes ☐ No Jaundice (yellow skin)
- ☐ Yes ☐ No Hiatal hernia
- ☐ Yes ☐ No Other intestinal disease
- ☐ Yes ☐ No Anemia
- ☐ Yes ☐ No Easy bruising or bleeding
- ☐ Yes ☐ No Are you or have you been an IV drug user?
- ☐ Yes ☐ No Are you currently employed? If yes, what type of work? _____
- ☐ Yes ☐ No Are you exposed to any hazardous chemicals in your work or otherwise?

- ☐ Yes ☐ No Fevers
- ☐ Yes ☐ No Nausea
- ☐ Yes ☐ No Heartburn
- ☐ Yes ☐ No Painful swallowing
- ☐ Yes ☐ No Black, tarry stools
- ☐ Yes ☐ No Blood in urine
- ☐ Yes ☐ No Previous gallbladder surgery
- ☐ Yes ☐ No Impotence
- ☐ Yes ☐ No Urinary or prostate problems
- ☐ Yes ☐ No Have you ever taken steroids
- ☐ Yes ☐ No Diabetes
- ☐ Yes ☐ No Angina (chest pain)
- ☐ Yes ☐ No Blood clots in lungs or heart
- ☐ Yes ☐ No Alcoholism
- ☐ Yes ☐ No Gallstones
- ☐ Yes ☐ No Diverticulitis
- ☐ Yes ☐ No Thyroid problems
- ☐ Yes ☐ No Stomach (gastric) or duodenal (peptic) ulcers
- ☐ Yes ☐ No Do you take aspirin or ibuprofen
- ☐ Yes ☐ No Have you had a blood transfusion
- ☐ Yes ☐ No Arthritis
- ☐ Yes ☐ No Skin diseases
- ☐ Yes ☐ No Neurologic illness
- ☐ Yes ☐ No Psychiatric illness:_____

Family and Social History

Marital status: ☐ Single ☐ Married ☐ Divorced

Do you Drink alcohol? ☐ Yes ☐ No How often: ☐Daily ☐Socially ☐Occasionally

Do you currently smoke cigarettes? ☐ Yes ☐ No How many packs/day? _____ For how long?_____

Is there any family history of:

☐ Yes ☐ No Cancer
☐ Yes ☐ No Heart disease
☐ Yes ☐ No Stroke
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Asthma or Emphysema
☐ Yes ☐ No Other serious health problems If yes, what are they?

_____

If either parent has died:

Mother's cause of death was _____ at age _____in what year? _____
Father's cause of death was _____ at age_____ in what year? _____

FEMALE PATIENTS:
Date of last menstrual period:_____ Are your menstrual periods regular? ☐ Yes ☐ No
Are you using birth control? _____ If yes, what type:_____
Number of Pregnancies: _____ Number of live births:_____

Children/Name & Age_____

Other comments: _____

_____

_____

_____

_____

Medical and Surgical History

Please provide a list of your medical history

Type of illness	Physician	Additional Comments

Have you had any previous surgeries? ☐ Yes ☐ No

Type of Surgery	Hospital/Location	Physician

Are you taking any medications? ☐ Yes ☐ No

Name of Medicine/Indication	Dosage	Frequency

Do you have any Food/Drug allergies? ☐ Yes ☐ No

If yes, to what?_____

Weight Reduction Programs

Current Weight_____ Weight 1 year ago_____ Wt 5 years ago_____

Previous Weight Reduction Efforts

Type of Program (Including Medications)	Year/Duration of effort	Weight Loss	Was all weight regained? (Yes Or No)

Most Effective Program?_____

Maximum Weight Loss Achieved? _____

List any program/effort monitored by a Physician:

_____
_____
_____
_____
_____