ADVANCED SURGICAL SOLUTIONS, LCC

7 Industrial Road, Suite 203
Pequannock, NJ 07440
Phone (973) 696-9050
Fax (973) 696-9055

140 Route 17 North, Suite 102
Paramus, NJ 07652
Phone (201) 265-0080
Fax (973) 696-9055

This packet is a thorough medical history and questionnaire designed for prospective patients interested in bariatric surgery to complete prior to coming to their first appointment at Advanced Surgical Solutions, LLC. We encourage you to take the time to work on this packet and to be as detailed as possible. We suggest you work on this packet on more than one occasion taking breaks as needed.

7 Industrial Road, Suite 203
Pequannock, NJ 07440
Phone (973) 696-9050
Fax (973) 696-9055

140 Route 17 North, Suite 102
Paramus, NJ 07652
Phone (201) 265-0080
Fax (973) 696-9055

MEDICAL HISTORY AND QUESTIONNAIRE

Name_____Address_____City_____
State_____Zip code_____Gender____D.O.B.___/___/____ Age_____

Birthplace_____Marital Status _____Occupation_____

Primary Care Physician_____telephone_____
address_____
Who may we thank for referring you to our practice?_____
When was your last physical examination?_____What were the results?_____

Medical History and Current Illnesses

(Please list any medial conditions for example tuberculosis, heart disease, high blood pressure, high cholesterol, diabetes (childhood onset), diabetes (adult onset), stroke, thyroid problems, emphysema, pneumonia, asthma, sleep apnea, heart attack, kidney/ liver /gallbladder / pancreatic disease, stomach ulcer, cancer, anemia, arthritis, osteoporosis, mental illness, seizure disorder, obesity, alcoholism)

Medical condition — Date Diagnosed

Surgical History

Previous surgeries/ procedures	Date	Surgeon	Hospital	Complications

Hospitalizations

Date	Reason	Name of Hospital	Length of stay	Treatment given

Injuries **Date**

Psychiatric History/Hospitalizations

Allergies- Medications, environment, foods, **latex** (Please list and describe reaction)

Medications

Medication name	Dosage (in mg)	Route (by mouth, injection, etc)	How often(?xday)
example. **Celebrex**	**100 mg**	**by mouth**	**2xday**

Do you take any non prescription medication or use any herbal products? (if yes, list)

Doctors currently treating you (Name, specialty, phone number)

Social History

Marital Status _____ Spouse's occupation _____ Number of children _____

If divorced, date of divorce _____

How much education have you completed? _____ Hobbies _____

What religion do you practice? _____ Do you live in an apartment or private house? _____

Do you have good support at home from family and relatives? _____

Do you feel afraid/in danger of anyone in your household? _____

Do you smoke cigarettes/use tobacco products? _____ How often and how much do you smoke? _____

For how many years have you smoked? _____

If you quit please tell us how much and for how long you had smoked for and when you quit _____

Do you drink alcohol? _____ What do you drink? _____ How much? _____ How often? _____

Are you ever criticized by family/ friends for your drinking? _____

Do you use recreational drugs? What kind and how often? _____

Do you like to gamble?_____

Do you have an exercise routine?_____What kind of exercises do you do?_____
How often do you exercise(time and # of days per week)_____

Diet History
This question is to give us an understanding of a day in your life. What do your meals usually consist of? Please take us through an average day starting from the moment you wake up to the moment you go to bed.

How many meals do you eat a day?_____Do you usually eat large meals at the end of the day?_____
Do you snack between meals?_____Do you eat just before going to bed?_____
Do you eat when you are sad?_____Do you like to eat sweets, candy, chocolate?_____
Do you enjoy milk products and yogurts?_____
Do you drink caffeine products?(coffee/tea/colas/espresso, iced tea, etc.)_____

Family History

Age Living/Deceased, State of Health (good, fair, poor), indicate any health problems

Father _____

Mother_____

Brother(s)/Sister(s)_____

Son(s)/Daughter(s)_____

Weight History
This section is extremely important. The information will be used for insurance approval

Were you overweight as a child? _____Were you overweight as an adolescent?_____
As a young adult?_____As an adult?_____For how many years have you been obese?_____
How has your weight changed in the last 5 years?_____
Where do you carry most of your weight?_____Current weight_____
Any recent weight gain or loss?_____Current height_____

List all medically (doctor) supervised programs you participated in.

Program (doctor) name	Cost	Dates Attended	Weight Lost	Weight Regained

List all non medical (commercial) weight loss programs you have participated in. (Example: Weight Watchers, Atkins Diet, South Beach Diet, LA Weight Loss).

Program name	Cost	Dates Attended	Weight Lost	Weight Regained

Please list any weight loss medications you have used or are using, include dates of use. (Example: Meridia, Xenical, Stacker, PhenFen).

Have you tried weight loss counseling groups? (Explain)

REVIEW OF SYSTEMS **(Please circle all that apply and describe in detail on line below)**

Skin: Any itching, dryness, color changes, rashes, lumps under skin, changes in hair, changes in your nails or changes in size/ color of any existing moles?

Head: Do you have headaches, dizziness, have you ever had any head injury in the past, or history of fainting?

Eyes: Do you wear glasses?_____ When was your last eye exam?_____
Do you have any eye pain, redness, excessive tearing, double vision, glaucoma, cataracts, blurred vision, loss of vision, or sensitivity to light?

Ears: Do you have any deafness, ringing in ears, do you feel like the room is spinning when you are standing still, do you have any ear pain, infection or discharge? Do you wear a hearing aid? _____

_____

Nose: Do you have any nasal dryness, frequent nosebleeds, burning sensation in your nose, excessive discharge from nose, sinus trouble, or any blockages in your nasal passages?

_____

Mouth and Throat:
Do you have all your teeth? _____Do you wear dentures? _____When was your last dental exam?_____
Do you have any difficulty chewing food? _____Have you ever been told you have TMJ problems?_____
Do you have any soreness of your tongue, bleeding from gums, sore throat, tonsil pain or any changes in your voice? _____

Neck: Do you have any lumps or enlarged lymph nodes on your neck?_____
Have you ever been told you have goiter?_____Do you have any neck pain or limitation of motion in you neck?_____

Respiratory System: Do you have cough, sputum, coughing up of blood, difficulty breathing, wheezing, asthma, bronchitis, emphysema, pneumonia, tuberculosis, pain in chest when coughing?

_____

_____

_____

Have you ever been tested for TB? _____When was your last chest X-ray and what was the result?_____
How many hours do you sleep a night?_____Do you wake up tired?_____
Do you snore?_____Do you have morning headaches?_____Do you fall asleep at work?_____

Cardiac System: When did you have your last Electrocardiogram (EKG) and what was the result?_____
Can you sleep flat on your back?_____ How many pillows do you sleep on and for how long have you used this many?_____
Do you have chest pain? Describe and does this pain move to other area of body?_____
Do you feel like your heart is racing?_____
Have you ever been told you have an irregular heart rhythm i.e. Atrial fibrillation?_____
Do you notice your lips/fingers or toes turning blue?_____
Do you have difficulty breathing when you are walking, exercising?_____
Do you have swelling of your legs/ arms/ ankles?_____
Do have a heart murmur?_____Do you have a pacemaker? _____
Do you ever awaken at night to catch your breath?_____
Have you ever used Phen-phen?_____Have you had an echocardiogram? (date and result)_____

Gastrointestinal System: **(Circle all that apply and describe on lines below)** Do you have any difficulty swallowing, nausea, vomiting, heartburn, recent change in appetite, vomiting up of blood, indigestion, black stools, diarrhea, constipation, abdominal pain, abdominal cramping, notice your skin or whites of eyes turn yellow, gallbladder problems, excessive burping or flatulence (passing gas), change in the width of your stool, or bleeding from your rectum upon defecation? Do you have trouble controlling your bowels?

_____

_____

_____

_____

_____

_____

Have you ever had a colonoscopy?_____If yes when and result:_____

Urinary System:
Are you urinating more frequently than usual?____Do you urinate a larger amount of urine than usual?_____
Do you have to wake up a lot to urinate at night?_____Do you have pain when urinating?_____
Do you notice blood in your urine?_____
Do you find yourself having to run to the bathroom to urinate?_____
When you are ready to urinate do you find you have to wait for your flow to begin?_____
Do you have any incontinence (unable to control your urination)?_____

Do you have any urinary infections?_____Have you ever had any kidney stones?_____
Have you notices a change in the color of your urine?_____
Do you have a reduction in the force of your stream of flow?_____

Male Patients Only
Do you have any history of Sexually Transmitted Disease? If yes please list condition and treatment you have received?_____
_____
Do you have any sores or discharge from your penis, any hernias, pain or lumps in your testicles?
_____
Do you practice the Testicular Self Exam?_____
Are you sexually active or abstinent? What form of birth control do you and your partner use?_____
Do you have any problems with your prostate? _____
Have you noticed a change in your libido(interest in sexual activity)? Please describe._____

Female Patients Only

At what age did you start having your period?_____Is your menstrual cycle regular or irregular?_____
How many days is your cycle?_____For how many days do you have bleeding?_____
Do you ever bleed between periods?_____When was your Last Menstrual Period?_____

Are you currently sexually active or abstinent?_____
Do you have any history of Sexually Transmitted Diseases? If yes, please list condition and treatment you have received._____
Do you have any painful sores or discharge from your vagina?_____

When was you last PAP exam and result?_____When was your last Mammogram and result?_____

Do you take Calcium supplements daily to prevent Osteoporosis?_____
Have you had a Bone Scan recently to evaluate you for Osteoporosis?_____
Do you practice the Breast Self Exam?_____
Have you noticed any rashes, masses or itching of your breasts?_____
Have you had any discharge from your nipples? If yes, describe._____
Have you noticed any texture or color change on the skin of your breasts?_____
How many times have you been pregnant?_____Where your children full term?_____
Where any of your children born prematurely?_____Have you ever had a miscarriage?_____
Have you ever terminated a pregnancy?_____Are any of your children adopted?_____
How is your libido?_____How often do you have intercourse?_____
Do you have any pain during intercourse?_____What form of birth control do you employ?_____
Do you use Oral contraceptives (pill)?_____

Have you gone through menopause?(if yes at what age)?_____
After menopause, have you had any bleeding?_____Have you ever used Hormone Replacement Therapy ?_____

Peripheral Vascular System:
Do you have a history of a vein clot, phlebitis, varicose veins, or been told you have intermittent claudication?____

Musculoskeletal System:
Do you have joint pain, swelling, stiffness, arthritis, gout, backache, muscle pain or cramps, fractures, dislocations, muscle weakness or wasting?(indicate location and describe)

Neurologic:
Do you have epilepsy, seizures, dizziness or have you ever lost consciousness?_____
Do you have any disturbance in your sense of smell or vision, numbness in your face or mouth, difficulty with chewing, weakness in your face, disturbance in your sense of taste, disturbance in hearing or balance, difficulties with speech/ swallowing?

Do you have any paralysis, reduction in muscle size, involuntary movements, uncontrollable shaking, or difficulty walking?

Do you have increased sensation, decreased sensation or no sensation in any part of your body? (Describe location and explain)

Psychiatric: Do you feel nervous / anxious, do you have a lot of tension, do you feel sad or have feelings of guilt, do you have frequent mood changes, do you have racing thoughts, or have you ever tried to hurt yourself, have you ever attempted suicide, have you ever been diagnosed with or treated for schizophrenia, borderline personality disorder, depression, or eating disorder?

Endocrine System:
Have you had any growth abnormalities, thyroid problems, heat or cold intolerance (example wearing snow jacket in summer or no jacket in winter), excessive thirst, feeling the need to eat even when full, change in hair distribution or abnormal breast development?

Hematologic:
Do you bruise easily, have anemia, history of leukemia, ever have a blood transfusion, or a bad reaction to a blood transfusion, are you on any blood thinning medication?, do you have hepatitis B or C, have you ever been tested for HIV?

Please answer the following True or False questions (Circle)

Having weight loss surgery will cure my obesity?	True / False
I don't have to exercise after I have surgery?	True / False
I will be able to eat a T-bone steak 1 week after surgery.	True / False
I will have to make behavioral changes after surgery to lose weight after surgery	True / False
I can eat any foods I please in any size portion after surgery?	True / False
I understand I must adhere to dietary guidelines in order to have good results	True / False
Portion size should remain under one cup at any one meal	True / False
I will be able to drink liquids while I eat solid food	True / False
After surgery I don't need to ever see my doctor again	True / False

Please write in your own words your experience living with morbid obesity?

Please write in your own words how you feel this procedure will change your life?

- THE END-

We would like to thank you for taking the time to give us this very personal and in depth information that will help us provide you with good medical care. If at any time you are uncertain about the meaning of any questions feel free to contact our office.