

LAPAROSCOPIC SURGERY FOR MORBID OBESITY
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CLINICAL HISTORY FORM

Last Name _____ First Name _____ MI _____ Date _____

GENERAL HISTORY

Gender Male Female Date of Birth _____ Age _____

Height _____ Weight _____

Which procedure are you interested in?

Roux en Y (Gastric Bypass) Adjustable Lap Band

Age of obesity onset:

0-2 years 2-12 years 12-18 years 20's Pregnancy Middle Age

How many years have you been at your present weight? _____

Were there any significant events that lead to your weight gain?

Loss of a loved one Pregnancy Other, _____
 Divorce Trauma, Accident or _____
 Loss of employment Illness, describe _____
 Depression _____

What is the most weight you have lost? _____ pounds

How long did you keep it off? _____

Do you smoke? Yes, how many cigarettes per day _____
 Quit, when _____
 Never

Do you have a history of, or presently use recreational drugs?

Yes No, describe _____

Do you drink alcoholic beverages? No Yes

If yes, Daily Weekly Monthly On occasions Never

PHYSICAL HISTORY

Do you have any of the following diagnoses, conditions, symptoms?
If so, please place a check in the box.

Endocrinology

- Diabetes insulin dependant
- Diabetes non-insulin dependant
- Hyperthyroid
- Hypothyroid
- Goiter
- Graves Disease

Neurology

- Numbness/tingling of feet or hands
- Seizures
- Epilepsy
- Stroke/TIA

Skin

- Dermatitis
- Rashes
- Open sores
- Psoriasis

Vascular

- Anemia
- Thrombocytopenia/low platelets
- Blood clot (s) in leg
- Pulmonary embolism
- Problems with Circulation in the legs
- Swelling of the legs
- Peripheral vascular disease

OB/GYN

- Irregular Periods
 - Difficulty getting pregnant
 - Excessively Painful Periods
 - Fibroids
 - Ovarian cysts
- Number of children _____
- Number of pregnancies _____
- Date of last mammogram _____
- Date of last Pap Smear _____

Gastrointestinal

- GERD (reflux disease)
- Heartburn
- Stomach Ulcer
- Duodenal Ulcer
- Constipation
- Diarrhea
- Vomiting
- Difficulty swallowing
- Rectal bleeding
- Abdominal pain
- Colitis
- Irritable Bowel Syndrome
- Crohn's Disease
- Gallbladder Disease
- Gallstones

Respiratory

- COPD
(Chronic Obstructive Pulmonary Disease)
- Emphysema
- Asthma or Chronic Bronchitis
- Sleep Apnea
- Shortness of breath upon exertion
- Snoring

Cardiovascular

- High blood pressure
- Palpitations
- Chest pain / Angina
- Blood clots (due to injury or surgery):
- Heart Attack
- Cardiomyopathy
- Congestive heart failure
- High cholesterol or Triglycerides

Infectious Disease

- Hepatitis (A, B or C):
- Cirrhosis
- HIV Positive
- Other, _____

Genito-Urinary

- Recurrent urinary tract infections
- Kidney stones
- Kidney disease
- Kidney failure (dialysis)
- Stress incontinence/ urinary frequency

Musculoskeletal

- Arthritis
- Back Pain
- Migraine headaches

- Gout
- Pain in weight-bearing joints
- Fibromyalgia

Psychological

- Depression
- Schizophrenia
- Bi-Polar Disorder
- Anxiety
- Suicide attempt
- Anorexia
- Bulimia

Please provide any other information you feel is pertinent which will help the doctor treat you:

MEDICATIONS / SUPPLEMENTS / HERBS USE

List in the table below anything you are currently taking on a regular basis:
(Make sure to include the following: aspirin, Heparin, Coumadin, Plavix, and Vitamin K)

Name of Item	Dose	Frequency	Start date	What is the reason for taking this?	Was this ordered by a doctor / who?

When was the date of your last physical exam and who is your doctor?

MAJOR MEDICAL HISTORY

Illness	Treatment	Date	Doctor

SURGICAL HISTORY

Procedure	Date

Have you experienced any problems associated with a surgery?
If so place a check in the box and briefly describe.

- Anesthesia, describe _____
- Infected wound, describe _____
- Bleeding, describe _____
- Clotting, describe _____
- Fever, describe _____
- Difficulty healing, describe _____
- Other _____, describe _____

MEDICAL FAMILY HISTORY

Does anyone in your family have/had the following?
If so, please place a check in the box and list who (sibling, parent, and/or grandparent).

- Obesity, who _____
- Hypertension, who _____
- Diabetes, who _____
- Cardiac problems/ Heart disease, who _____
- Stroke, who _____
- Lung disease, who _____
- Liver disease, who _____
- Arthritis, who _____
- Cancer, who _____
- Blood clots, who _____
- Early death, who and describe _____

ALLERGIES

Are you allergic to any medications? YES NO

Medication _____ Reaction _____

Medication _____ Reaction _____

Are you allergic to any foods? YES NO

Food _____ Reaction _____

Food _____ Reaction _____

Are you allergic to any materials? YES NO (ex. Latex, Iodine, surgical tape)

Material _____ Reaction _____

Material _____ Reaction _____

MEDICALLY SUPERVISED DIETS

PLEASE SUPPLY AS MUCH INFORMATION AS POSSIBLE					
	Dr. / Clinic	Year	Duration	Pounds lost	Pounds regained
In-Patient Programs					
Rader Institute					
Other:					
Other:					
Supervised Outpatient					
Opti-Fast					
Medi-Fast					
Registered Dietitian					
Prescription Diets					
Meridia					
Amphetamines					
Phen-Fen					
Fastina					
Xenical					
Lonomin					
Didrex					
Phentermine					
Pondimine					
Redux					
Paxil					
Wellbutrin					
Celexa					
Prozac					
Sarafen					

Lasix					
Adipex					
HcG/13-6/13-12 Shots					
Reduced Calorie Diets					
1,000 Cal/day					
1,200 Cal/day					
1,500 Cal/day					
2,200 Cal/day					
Other:					
Limited Intake					
Lo Cholesterol					
Lo Carb					
Alternative Therapies					
Gastric Bubble					
Hypnosis					
Jaw Wiring					
Acupuncture					

NON-MEDICALLY SUPERVISED WEIGHT LOSS METHODS

Please place a check in the box if you have tried any of the following.

- | | | |
|---|--|--|
| <input type="checkbox"/> Jenny Craig | <input type="checkbox"/> Imperial Fitness | <input type="checkbox"/> Fitness USA |
| <input type="checkbox"/> Acutrim | <input type="checkbox"/> Mayo Clinic Diet | <input type="checkbox"/> Sugar Busters Diet |
| <input type="checkbox"/> 24 Hr Fitness | <input type="checkbox"/> New Dimensions | <input type="checkbox"/> Dance Tapes |
| <input type="checkbox"/> Nutri/System | <input type="checkbox"/> Cambridge diet | <input type="checkbox"/> Slim Down Express |
| <input type="checkbox"/> Dexatrim | <input type="checkbox"/> American Health Spa | <input type="checkbox"/> The Anti-Diet |
| <input type="checkbox"/> Lydia's Health Spa | <input type="checkbox"/> Venus Di Milo Gym | <input type="checkbox"/> Tae Bo Tapes |
| <input type="checkbox"/> Weight Watcher's | <input type="checkbox"/> World Gym | <input type="checkbox"/> Ladies Spa |
| <input type="checkbox"/> Diuerex | <input type="checkbox"/> Susan Powter | <input type="checkbox"/> CA Slim |
| <input type="checkbox"/> Curves | <input type="checkbox"/> Rich Simmons Tape | <input type="checkbox"/> Dance Classes |
| <input type="checkbox"/> TOPS | <input type="checkbox"/> Vic Tanny Fitness | <input type="checkbox"/> Bally's Super Centers |
| <input type="checkbox"/> Xenadrine | <input type="checkbox"/> South Beach Diet | <input type="checkbox"/> Super Dieter's Tea |
| <input type="checkbox"/> LA Fitness | <input type="checkbox"/> Denise Austin | <input type="checkbox"/> Exercise Classes |
| <input type="checkbox"/> Over Eater's | Workout | <input type="checkbox"/> Beverly Hills diet |
| Anonymous | <input type="checkbox"/> YMCA | <input type="checkbox"/> Personal Trainer |
| <input type="checkbox"/> Herbal Phen/Fen | <input type="checkbox"/> Slim Fast | <input type="checkbox"/> BioSlim |
| <input type="checkbox"/> California Fitness | <input type="checkbox"/> Jane Fonda Workout | <input type="checkbox"/> Home gym |
| <input type="checkbox"/> Loma Linda Med. Ctr. | <input type="checkbox"/> Slender Lady Spa | <input type="checkbox"/> Herbalife |
| <input type="checkbox"/> Metabolife | <input type="checkbox"/> Weigh Down Diet | <input type="checkbox"/> Fasting |
| <input type="checkbox"/> Sports Center | <input type="checkbox"/> Jazzercise Tapes | <input type="checkbox"/> Hollywood 24-Hour |
| <input type="checkbox"/> (Rotation or Cabbage | <input type="checkbox"/> Sports Plus | <input type="checkbox"/> Body Solutions |
| <input type="checkbox"/> Metabolite | <input type="checkbox"/> Sweet Success | |
| <input type="checkbox"/> Family Fitness | <input type="checkbox"/> Aerobics Tapes | |
| <input type="checkbox"/> Richard Simmons | | |
| Deal-A-Meal | | |

TO ALL GASTRIC BYPASS AND LAP-BAND PATIENTS

Please be advised of the following office procedures:

1. If your insurance company fails to cover the \$300 consultation fee, you will be responsible for this fee. Your surgery will not be scheduled unless it is paid.
2. Lap-Band adjustments are \$185.00. Payment is required prior to the procedure.
3. The \$300.00 program fee must be paid at the time of consent or we will not be able to submit your paperwork to your insurance company.
4. We cannot schedule surgery until we receive written approval from your insurance company.

Program Fee Acknowledgement

Vital components to successful Bariatric surgery are pre and post-op education, support groups and follow-up care. We are committed to providing you with the resources necessary to make this process as successful and rewarding as possible.

Our program offers professionals, versed in the Bariatric field, who will provide you with the educational and emotional support needed to reach your goals. We offer the tools and knowledge needed to adjust to the physical and psychological changes that occur during this transition period.

In addition to these services, Dr. Ferzli and his staff are committed to responding to your needs and concerns.

Please print your name and sign where indicated, as this will confirm that you fully understand the above. You further acknowledge that you have received information regarding your bariatric surgeon's experience and patient outcomes as they relate to obesity surgery.

Thank you for your cooperation.

Name (Print) _____

Name (Signature) _____ Date _____