Patient Profile

Personal Information

Date: _____

Last Name: _____First Name: _____ M.I. _____

Ethnic Group:
___Caucasian ___African American ___Hispanic
___Asian ___Native American Other:_____

Date of Birth: _____ SS#: _____-_____-_____

Home Address:_____ Apt.#:_____

City:_____ State:_____ Zip: _____

Telephone (Home): _____ (Work): _____

(Cell): _____ (Pager): _____

E-mail: _____

Marital Status:
___ Never Married ___ Married ___ Divorced
___ Widowed ___ Separated ___ Significant Other

Spouse's/Significant Other's Name: _____ or N/A

Referral Information

How did you hear about us? Please check all that apply.

___ Physician ___ Other patient ___ Newspaper

___ Television ___ E-mail ___ Yellow pages

Referring Doctor: _____ Date of referral: _____

Address:_____

Telephone #: _____ Fax #: _____

Contact Person(s)

This information is vital to us if we need to contact you urgently. Occasionally people move or have new phone numbers and do not update our office.

NEXT OF KIN (NOT LIVING WITH YOU)

Name: _____

Relationship: _____

Address:_____

_____

Telephone (Home): _____

Telephone (Work): _____

Occasionally it is beneficial to you for us to discuss your confidential information such as spouse, partner, family member, etc.

_____ (Initial) I do not authorize Dr. Berger or Dr. Aldridge to discuss my confidential information with anyone.

_____ (Initial) I authorize Dr. Berger or Dr. Aldridge to discuss my confidential information with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Your Signature: _____

Physicians

Primary Care Physician: _____
Address: _____
Telephone # ( )_____ - _____ Fax # ( ) _____ - _____

Cardiologist (Heart): _____
Address: _____
Telephone # ( )_____ - _____ Fax # ( ) _____ - _____

Psychologist: _____
Address: _____
Telephone # ( )_____ - _____ Fax # ( ) _____ - _____

Pulmonologist (Lungs): _____
Address: _____
Telephone # ( )_____ - _____ Fax # ( ) _____ - _____

Gastroenterologist (GI doctor): _____
Address: _____
Telephone # ( )_____ - _____ Fax # ( ) _____ - _____

Orthopedic Surgeon: _____
Address: _____
Telephone # ( )_____ - _____ Fax # ( ) _____ - _____

Endocrinologist: _____
Address: _____
Telephone # ( )_____ - _____ Fax # ( ) _____ - _____

Other: _____
Address: _____
Telephone # ( )_____ - _____ Fax # ( ) _____ - _____

Weight and Weight Loss History

Height Feet_____ Inches_____

Weight _____

Age of obesity onset:

_____ 0-2 years old

_____ 2-12 years old

_____ 12-18 years old

_____ Young adult

_____ Pregnancy

_____ Middle age

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

Greatest single weight loss _____ pounds

Weight loss was sustained for _____ years _____ months

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

_____ Loss of a loved one _____ Trauma – accident or illness

_____ Pregnancy _____ Loss of employment

_____ Other

Have you had medically-supervised weight loss in the past? _____ Yes _____ No

By whom and what date(s)?

1. _____

2. _____

3. _____

4. _____

Detailed Diet History

Fill in the dates you participated in the following diet programs, as well as how much weight lost, and the amount regained after stopping the program.

PROGRAM	FROM	TO	# MOS	POUNDS LOST	POUNDS REGAINED
Accupuncture					
Weight Watchers					
Nutrisystem					
Scarsdale					
Diet Center					
Jenny Craig					
Dexatrim					
Grapefruit Diet					
Atkins					
Slim Fast					
Overeaters Anon.					
Herbal Diets					
Hypnosis					
TOPS					
Calorie Counting					
Richard Simmons					
Low Fat					
Exercise Program					
Cabbage Diet					
American Heart Association					
Psychiatric programs					
Optifast					
Carefast					
MEDICATION	**FROM**	**TO**	**# MOS**	**POUNDS LOST**	**POUNDS REGAINED**
Meridia					
Xenical					
Fastin					
Ionamin					
Phenteramine/Fenfluramine					

Past Medical History

Head and Neck

_____ Glaucoma
_____ Cataracts
_____ Hearing Loss
_____ Vertigo
_____ Tinnitus
_____ Migraine Headaches
Other: _____

Cardiovascular

_____ High blood pressure
_____ Irregular heartbeat
_____ Congestive heart failure
_____ Coronary artery disease
_____ Heart valve problems/murmur
_____ High cholesterol/lipids
Other: _____

Pulmonary

_____ Pulmonary hypertension
_____ Right heart failure
_____ Obstructive sleep apnea
_____ Chronic obstructive pulmonary disease (COPD)
_____ Emphysema
_____ Asthma
_____ Childhood asthma, resolved
_____ Tobacco use
_____ Pulmonary embolus
Other: _____

Gastrointestinal

_____ Gastroesophageal Reflux (GERD)
_____ Ulcers Circle if known: Stomach Duodenal
_____ Diverticulosis
_____ Diverticulitis
_____ Gallstones
_____ Non-Alcoholic Steatohepatitis (NASH)
_____ Cirrhosis
_____ Portal hypertension
_____ Pancreatitis
_____ Adhesive bowel disease
Other: _____

Past Medical History - Continued

Genitourinary

_____ Kidney Stones
_____ Urinary Incontinence
_____ Kidney failure
_____ Urinary tract infection
_____ Kidney infection
_____ Gout
Other: _____

Gynecologic

_____ Excessively heavy periods (Menorrhagia)
_____ Infertility
_____ Polycystic Ovary Disease
Other: _____

Endocrine

_____ Diabetes
_____ Hypothyroidism
_____ Hyperthyroidism
_____ Goiter
_____ Graves disease
Other: _____

Neurologic

_____ Stroke
_____ Seizure disorder
_____ Epilepsy
_____ Carotid artery disease
Other: _____

Blood

_____ Anemia
_____ Deep venous thrombosis (blood clots)
_____ Low platelets (Thrombocytopenia)
Other: _____

Psychologic

_____ Anxiety disorder
_____ Depression
_____ Bi-polar disorder
_____ Schizophrenia
_____ Anorexia
_____ Bulimia
Other: _____

Past Medical History - Continued

Substance Abuse

_____ Intravenous Drugs
_____ Tobacco
_____ Alcoholism
Other: _____

Infectious Disease

_____ HIV positive
_____ Hepatitis Circle any that apply: A B C Other_____
Other: _____

Musculoskeletal

_____ Rheumatoid arthritis
_____ Osteoarthritis (Degenerative joint disease)
_____ Plantar fasciitis
Other: _____

Past Surgical History

Please indicate with a check any of the following surgeries you have had and the year performed

Type of surgery	Had Surgery?	Laparoscopic or open?	Year?
Abdominal/Pelvic			
Appendectomy			
Cesarean Section			
Gallbladder, Open			
Gallbladder, Laparoscopic			
Gastric Bypass			
Gastric Band			
Hernia repair, abdominal			
Mesh? ____Y ___ N			
Hernia repair, umbilical			
Mesh? ____ Y___ N			
Hernia repair, inguinal			
Hysterectomy			
Liposuction			
Ovarian cystectomy			
Panniculectomy			
Prostate Surgery			
Tubal ligation			
Vertical Banded Gastroplasty			
Orthopedic/Spine			
Ankle surgery			
Back surgery			
Knee surgery			
Lumbar Laminectomy			
Lumbar Fusion			
Other			
Adenoidectomy/Tonsillectomy			
Breast Surgery			
Carpal Tunnel surgery			
Coronary bypass (heart)			
Other heart surgery (e.g. valve)			
Eye surgery			
Oral surgery			
Pilonidal cystectomy			
Wisdom teeth			
Other(s):_____			

Any problems with anesthesia? ____ Y ____ N Describe: _____

Medications

Please list all prescription medications you are currently taking. Please take the information from the prescription label.

Name of Medication	Dose (mg, units, etc.)	Frequency (e.g. once a day)	Used for:

Please list all herbal supplements, over the counter drugs, vitamins, etc. Include any medications recently stopped (within 6 months). Specifically address any use of aspirin, coumadin, lovenox, ibuprofen, garlic, vitamin E.

Name	Dose (mg, units, etc.)	How often used	Last time used

ALLERGIES

Allergies to Medications

_____ NO KNOWN DRUG ALLERGIES

DRUG	IF ALLERGIC, PLEASE CHECK	INDICATE REACTION
Aspirin		
Codeine		
Iodine		
Penicillin		
Keflex		
Sulfa		

Other allergies:

_____ Latex
_____ Food allergies To what food(s): _____
_____ Tape
_____ Heparin
_____ Anesthesia Indicate reaction: _____

Social History

Family Structure:

_____ Married _____ Live with significant other
Name: _____
_____ Separated _____ Divorced _____ Widowed _____ Single
Other: _____

_____ Number of children Age(s):_____
_____ Number of other people who live with you
If others live with you, who are they?_____

Support person(s): _____

How do the people around you feel about you considering surgery? _____

Social history – Continued

Are you currently employed? YES _____ NO _____

Occupation:_____

Employer: _____

Do you enjoy your work? YES _____ NO _____

If you are unemployed, how long? _____

Reason:

_____ Physically unable to work _____ Emotionally unable to work
_____ Lack of available jobs in the field _____ Lack of skills
_____ Feeling that appearance is inappropriate for job sought
Other: _____

Are you currently disabled or on disability? YES _____ NO _____
If so, how long? _____

Education:

_____ some high school or less
_____ High school graduate or G.E.D.
_____ Some college
_____ College graduate
_____ Post graduate work Degree? _____

Do you drink coffee? YES _____ NO _____ # cups/day _____

Do you smoke cigarettes? YES _____ NO _____
_____ Cigarettes per day OR _____ Packs of cigarettes per day

Do you smoke cigars? YES _____ NO _____ # cigars/week _____

Do you drink alcohol? YES _____ NO _____
If so, describe: _____ Rarely _____ Frequently _____ Moderately
Specifically describe the number of drinks per day, week OR month _____ per _____

Do you or have you used intravenous drugs? YES _____ NO _____

Have you had a problem with substance addiction? YES _____ NO _____
_____ Drugs _____ Alcohol _____ Tobacco _____ Other
If yes, how long ago did you quit? _____ Months
What treatment did you receive? _____ None _____ Outpatient counseling
_____Support groups such as AA _____ Inpatient treatment

Family History

Please describe your family medical history.

Father:
_____ Living _____ Deceased If deceased, age: _____

Cause of death: _____

History of: _____ Obesity _____ Heart Disease _____ High blood pressure
_____ Diabetes _____ Cancer If cancer, type: _____

Mother:
_____ Living _____ Deceased If deceased, age: _____

Cause of death: _____

History of: _____ Obesity _____ Heart Disease _____ High blood pressure
_____ Diabetes _____ Cancer If cancer, type: _____

Brother(s):
_____ Living Age(s): _____
_____ Deceased Age(s): _____

Cause(s) of death: _____

History of: _____ Obesity _____ Heart Disease _____ High blood pressure
_____ Diabetes _____ Cancer If cancer, type: _____

Sister(s):
_____ Living Age(s): _____
_____ Deceased Age(s): _____

Cause(s) of death: _____

History of: _____ Obesity _____ Heart Disease _____ High blood pressure
_____ Diabetes _____ Cancer If cancer, type: _____

Children:
History of: _____ Obesity _____ Heart Disease _____ High blood pressure
_____ Diabetes _____ Cancer If cancer, type: _____

Any family history of problems with anesthesia? YES _____ NO _____
What Problem?_____
Any family history of bleeding or bruising? YES _____ NO _____

Personal Medical Information

Head and Neck

Do you wear glasses? YES _____ NO _____
Do you wear contacts? YES _____ NO _____
Do you have regular dental checkups? YES _____ NO _____
Have you had previous dental surgery? YES _____ NO _____
Do you wear dentures? YES _____ NO _____
Do you have missing teeth? YES _____ NO _____

Cardiac

Have you ever had:
EKG? YES _____ NO _____
If yes, NORMAL ____ ABNORMAL ____ FURTHER TESTING REQUIRED ____
Echocardiogram? YES _____ NO _____
If yes, NORMAL ____ ABNORMAL ____ FURTHER TESTING REQUIRED ____
Stress Test? YES _____ NO _____
If yes, NORMAL ____ ABNORMAL ____ FURTHER TESTING REQUIRED ____
Cardiac Catheterization? YES _____ NO _____
If yes, NORMAL ____ ABNORMAL ____ FURTHER TESTING REQUIRED ____

Have you ever had a heart attack? YES _____ NO _____
Do you have chest pain? YES _____ NO _____
If yes, describe:_____
With exertion only? YES _____ NO _____
Heart palpitations? YES _____ NO _____
Ankle swelling? YES _____ NO _____
Varicose veins? YES _____ NO _____
Leg ulcers? YES _____ NO _____
Irregular heart beats? YES _____ NO _____
Shortness of breath with exertion? YES _____ NO _____

Pulmonary (Lungs)

Have you ever been hospitalized for a pulmonary problem? YES _____ NO _____
What problem? _____
Date(s)? _____
In the ICU? YES _____ NO _____
On a ventilator (breathing machine)? YES _____ NO _____
Have you ever been on steroids for a lung problem? YES _____ NO _____
Short-term steroids _____ Chronic/long-term steroids _____

Pulmonary (Lungs) - Continued

How well rested do you feel after a full night's sleep?
_____ Not at all _____ Somewhat _____ Well Rested

Do you feel more comfortable sleeping in an upright position?
YES _____ NO _____
Do you use C-Pap? YES _____ NO _____
Do you use Bi-Pap? YES _____ NO _____

Snorting or gasping during sleep	YES _____	NO _____
Loud snoring	YES _____	NO _____
Breathing stops/Choke or struggle for breath	YES _____	NO _____
Frequent awakenings	YES _____	NO _____
Tossing, turning or thrashing	YES _____	NO _____
Difficulty falling asleep	YES _____	NO _____
Morning headaches	YES _____	NO _____
Night sweats	YES _____	NO _____
More than two pillows under head	YES _____	NO _____
Falling asleep at work or school	YES _____	NO _____
Falling asleep while driving	YES _____	NO _____
Excessive daytime sleepiness	YES _____	NO _____
Awaken feeling paralyzed, unable to move	YES _____	NO _____

Wheezing?	YES _____	NO _____
Chronic cough?	YES _____	NO _____
History of tobacco use?	YES _____	NO _____

Gastrointestinal/GERD (Gastroesophageal Reflux Disease)

How often do you have reflux (heartburn/regurgitation) during the day?
Many times Per day _____ Everyday _____ Most days _____ Most weeks _____
Infrequent _____

Do you suffer from heartburn/indigestion during the night? YES _____ NO _____
If so, how often?
Many times per night _____ Every night _____ Most nights _____
Most weeks _____ Infrequent _____

Does food or acidic fluid reflux in the mouth?	YES _____	NO _____
Do you vomit with reflux?	YES _____	NO _____
Do you have frequent diarrhea?	YES _____	NO _____
_____ Every day? _____ Occasionally?		
Chronic constipation?	YES _____	NO _____
Vomiting?	YES _____	NO _____
_____ Every day? _____ Occasionally?		

Gastrointestinal/GERD (Gastroesophageal Reflux Disease) - Continued

Treatments that you may use for reflux, heartburn or indigestion:
Check all those that apply:

_____ Zantac _____ Tagamet _____ Pepcid _____ Prevacid
_____ Nexium _____ Prilosec _____ Surgery

Abdominal pain after meals? YES _____ NO _____
Frequent bloating? YES _____ NO _____
Frequent loose stools? YES _____ NO _____

Genitourinary

Stress incontinence? YES _____ NO _____
Urinary frequency? YES _____ NO _____
Frequent urinary tract infections? YES _____ NO _____
Vaginal discharge? YES _____ NO _____
Irregular periods? YES _____ NO _____
Excessively painful periods? YES _____ NO _____
Excess body hair or acne? YES _____ NO _____
Difficulty in conceiving? YES _____ NO _____
Are you currently taking birth control pills? YES _____ NO _____

Endocrine

Have you been diagnosed with thyroid disease? YES _____ NO _____
What type? Hypothyroidism _____ Hyperthyroidism _____
Thyroid Nodules _____ Thyroid surgery _____

Have you been diagnosed or treated for diabetes? YES _____ NO _____
If so, please complete the following section:

Juvenile Onset YES _____ NO _____ Year diagnosed _____
Adult Onset YES _____ NO _____ Year diagnosed _____

Current form of control:

Diet control only YES _____ NO _____ As of (year) _____
Oral medication YES _____ NO _____ As of (year) _____
Insulin injections YES _____ NO _____ As of (year) _____
Number of insulin injections per day on average _____

Have you had Hemoglobin A1C levels tested (glycosylated hemoglobin)?
YES _____ LEVEL _____
NO _____

General

Have you ever been diagnosed with cancer? YES _____ NO _____
If so, check all that apply
_____ Breast _____ Endometrial _____ Prostate _____ Colon
_____ Thyroid _____ Skin _____ Blood _____ Other
Year Diagnosed? _____ Cancer free for _____ years
Treatment? Check all that apply.
_____ Surgery _____ Chemotherapy _____ Radiation _____ Medication
Are you planning a pregnancy in the next 2 years? YES_____ NO_____ N/A_____
Can you walk up a flight of stairs? YES_____ NO_____
If no, what limits you? _____

Musculoskeletal

Chronic back pain? YES _____ NO _____
Chronic hip pain? YES _____ NO _____
Chronic knee pain? YES _____ NO _____
Chronic ankle pain? YES _____ NO _____
Heel spurs? YES _____ NO _____
Have you ever had a hernia? YES _____ NO _____
If so, what type? (Check all that apply)
_____ Umbilical _____ Inguinal (groin) _____ Abdominal/Incisional
_____ Other

Neurologic

Numbness or weakness? YES _____ NO _____
Tingling of hands or feet? YES _____ NO _____

Blood

Anemia? YES _____ NO _____
Have you had a previous blood transfusion? YES _____ NO _____
If so, date: _____ Reason: _____

Other
Please list any current medical conditions or concerns not covered above.

_____

_____

_____
Details of any other hospitalizations for medical problems.

_____

_____