

# 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.

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

\_\_\_\_\_ I authorize Dr. Berger or Dr. Aldridge to discuss my confidential information  
(Initial) 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.

<b>PROGRAM</b>	<b>FROM</b>	<b>TO</b>	<b># MOS</b>	<b>POUNDS LOST</b>	<b>POUNDS REGAINED</b>
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					
<b>MEDICATION</b>	<b>FROM</b>	<b>TO</b>	<b># MOS</b>	<b>POUNDS LOST</b>	<b>POUNDS REGAINED</b>
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?
<b><u>Abdominal/Pelvic</u></b>			
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			
<b><u>Orthopedic/Spine</u></b>			
Ankle surgery			
Back surgery			
Knee surgery			
Lumbar Laminectomy			
Lumbar Fusion			
<b><u>Other</u></b>			
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: \_\_\_\_\_



# 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.

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Details of any other hospitalizations for medical problems.

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