Carson D. Liu MD Medical Corporation
Skylex Advanced Surgical, Inc.

Office: (310) 208-0474
Fax: (310) 208-0374

Contact Information			
Name	Last	First	
Address			
Emergency Contact Phone Number & Relationship			
Email Address			
Contact Phone	Home ( )	Work ( )	Mobile ( )
Social Security No.			
Demographic			
Date of Birth		Age	
Gender	☐ Female	☐ Male	
Height and Weight	Height Ft. In.	Current Weight	
Employment Information			
Are you employed?	☐ No	☐ Yes, occupation: _____	
Employer Name			
Employer Address and Phone			
Insurance Information			
Insurance Company Name	Primary Insurance	Secondary Insurance	
Insurance Address and Phone			
Member ID			
Group Number			
Plan Name/Type			
Relationship to Insured			
If your relationship to the Insured is **not "Self,"** please complete the section below:			
Insured Person's Name	Primary Insurance	Secondary Insurance	
Insured's Group Number			
Subscriber ID			

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Primary Care Physician	
Physician Name	
Physician Address and Phone	

Referral Information	
How did you hear about us?	☐ Physician ☐ Family/Friend ☐ Website ☐ Radio/TV ☐ Yelp ☐ Other
Referring Physician Name	
Physician Address and Phone	
Who can we thank for this referral?	

Weight Loss History		
Main reason for wanting surgery?		
Have you ever consulted other physicians about weight loss surgery? Please include physician name(s).		
From what age have you been obese? When did you begin to have issues with your weight?		
Have you attempted to diet? Please indicate number of weight loss methods tried to date.		
Lifetime Experiences	Lifetime Maximum Weight:	Highest Weight Loss from Single Diet:

Medically-Supervised Diet History in the Past 6 Years		
1. Name of Program:	Start and End Dates/Duration	Supervising Physician Name and Phone
Weight Lost:	Weight Regained:	Medication:
2. Name of Program:	Start and End Dates	Supervising Physician Name and Phone
Weight Lost:	Weight Regained:	Medication:
3. Name of Program:	Start and End Dates	Supervising Physician Name and Phone
Weight Lost:	Weight Regained:	Medication:
4. Name of Program:	Start and End Dates	Supervising Physician Name and Phone
Weight Lost:	Weight Regained:	Medication:

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Commonly Prescribed Weight Loss Medication		
Have you ever taken prescribed medication for weight loss?	☐ No	☐ If yes, please check all ever taken:
☐ Amphetamines	☐ Diethylpropin	☐ Pondamine/Fenfluramine
☐ Benzphetamine/Didrex	☐ Ionamin/Adipex (Phentermine)	☐ Prozac (Fluoxetine)
☐ Bontril/Phendimetrazine	☐ Meridia (Sibutramine)	☐ Redux (Dexfenfluramine)
☐ Dexedrine/Dextroamphetamine/Liquadd	☐ Phen-Fen	☐ Other, _____

Non-Medically Supervised Diet History in the Past 6 Years

Which diet programs/methods have you tried in the past 6 years? Weight Watchers, Jenny Craig, Overeaters Anonymous, Nutri-System, Atkins, High Protein, Low Carbohydrate, Low Fat, Calorie Counting, Hypnosis, Health Spa diets, Optifast, Slim Fast, etc. Please describe your diet experiences below.

Name of Diet:	Start and End Dates/Duration:	Weight Lost:	Weight Regained:	Medication:
Name of Diet:	Start and End Dates/Duration:	Weight Lost:	Weight Regained:	Medication:
Name of Diet:	Start and End Dates/Duration:	Weight Lost:	Weight Regained:	Medication:
Name of Diet:	Start and End Dates/Duration:	Weight Lost:	Weight Regained:	Medication:
Name of Diet:	Start and End Dates/Duration:	Weight Lost:	Weight Regained:	Medication:

Common Over-the-Counter Weight Loss Drugs		
Have you ever taken over-the-counter drugs for weight loss?	☐ No	☐ If yes, please check all ever taken:
☐ Alli	☐ Fastin	☐ Phendinet/Pentrol
☐ Accutrim	☐ Hoodia	☐ Plegine
☐ Anorex	☐ Mazanor	☐ Sanorex
☐ Dexatrim (Phenylpropanolamine)	☐ Obalan	☐ Tepanol

Surgical History

Procedure:	Date:	Physician:	Problems, if any:
1.			
2.			
3.			
4.			
5.			

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Medical History: Current Illnesses and Health Issues	
Illness and Issues:	Explain:
1.	
2.	
3.	
4.	
5.	
6.	

Medical History: Current Medications and Allergies			
What medications are you currently taking? Please list below.			
MEDICINE	DOSAGE		FREQUENCY
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
Have you ever taken Phen-Fen?	☐ Yes	☐ No	For how long?
Are you allergic to any medications? (If yes, list medications)		☐ Yes	☐ No
MEDICATION		REACTION	
1.			
2.			
3.			
Do you have allergies, including foods? (If yes, list allergies)		☐ Yes	☐ No
ALLERGIES		REACTION	
1.			
2.			
3.			
Check if you have any of these specific allergies.	☐ Hay Fever	☐ Soybean ☐ Egg ☐ Eczema ☐ Iodine	

Social History: Eating Habits		
Do you eat breakfast?	☐ 3 or more days a week	☐ 1 or 2 days a week
Do you snack at night?	☐ 3 or more days a week	☐ 1 or 2 days a week
Do you snack during the day?	☐ 3 or more days a week	☐ 1 or 2 days a week
Do you drink soda or very sugary liquids?	☐ 3 or more days a week	☐ 1 or 2 days a week

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Do you eat desserts?	☐ 3 or more days a week		☐ 1 or 2 days a week
Do you eat fried foods?	☐ 3 or more days a week		☐ 1 or 2 days a week
Do you binge eat? (Binge eating is when you eat a lot more than you feel you should eat)	☐ 3 or more days a week		☐ 1 or 2 days a week
How large are your meals compared to normal weight people eating the same meal?	☐ Smaller	☐ Similar	☐ Larger
Social History: Sleeping Habits			
How often do you have restless sleep or frequent awakening?	☐ 2 or more days a week		☐ Fewer than 2 days a week
How often do you have night sweats?	☐ 2 or more days a week		☐ Fewer than 2 days a week
How often do you snore?	☐ 2 or more days a week		☐ Fewer than 2 days a week
How often do you have daytime sleepiness?	☐ 2 or more days a week		☐ Fewer than 2 days a week
How often do you have morning headaches?	☐ 2 or more days a week		☐ Fewer than 2 days a week
Do you wake at night with a snort or gasp?	☐ No	☐ Yes, please explain and indicate frequency:	
In the past year, has anyone told you that you held your breath for a long time while asleep?	☐ No	☐ Yes, please explain and indicate frequency:	
Social History: Personal Habits			
Do you smoke?	☐ No	☐ Yes, cigarettes _____ or _____ packs per day How many years? _____	
Do you drink alcohol?	☐ No	☐ Less than 2 per month	☐ Once a week ☐ Daily
Have you ever been in an alcohol/drug dependency/substance abuse rehabilitation program?	☐ No	☐ Yes, please specify:	
Do you use recreational drugs?	☐ No	☐ Yes, please explain and indicate frequency:	
Family History			
Counting **yourself**, your full brothers and sisters, and your parents, how many people are in your immediate family?		No. _____	
How many people in your immediate family **(yourself included)** were at one time or another 75 lbs. or more overweight?		No. _____	
Has any blood relative ever had a problem with anesthetics (e.g. malignant hyperthermia)		☐ No	☐ Yes

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Does anyone in your family have diabetes?	☐ No	☐ Yes	Relation:
Does anyone in your family have high blood pressure?	☐ No	☐ Yes	Relation:
Does anyone in your family have heart disease?	☐ No	☐ Yes	Relation:
Does anyone in your family have gallstones?	☐ No	☐ Yes	Relation:

Review of Systems: Cardiovascular			
Heart attack	☐ Yes ☐ No	Heart Bypass/Valve Replacement	☐ Yes ☐ No
Angina (chest pain with activity)	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Rhythm Disturbance/Palpitations	☐ Yes ☐ No	Clogged Heart Arteries	☐ Yes ☐ No
Congestive Heart Failure	☐ Yes ☐ No	Rheumatic fever/Valve Damage	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No
Ankle Swelling	☐ Yes ☐ No	Irregular Heart Beat	☐ Yes ☐ No
Varicose Veins	☐ Yes ☐ No	Cramping in Legs when Walking	☐ Yes ☐ No
Phlebitis	☐ Yes ☐ No	Other _____	☐ Yes ☐ No
Ankle/Leg Ulcers	☐ Yes ☐ No		

Review of Systems: Respiratory			
Asthma	☐ Yes ☐ No	Pulmonary Embolism	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Hypoventilation Syndrome	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Cough up Blood	☐ Yes ☐ No
Pneumonia	☐ Yes ☐ No	Snoring	☐ Yes ☐ No
Chronic Cough	☐ Yes ☐ No	Sleep Apnea	☐ Yes ☐ No
Shortness of Breath	☐ Yes ☐ No	Lung Cancer	☐ Yes ☐ No
Use of CPAP or Oxygen Supplement	☐ Yes ☐ No	Lung Surgery	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No	Other _____	☐ Yes ☐ No

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Review of Systems: Endocrine			
Hypothyroid (low)	☐ Yes ☐ No	Diabetes (managed by diet or pills)	☐ Yes ☐ No
Hyperthyroid (high/overactive)	☐ Yes ☐ No	Diabetes (needing insulin shots)	☐ Yes ☐ No
Goiter	☐ Yes ☐ No	"Pre-diabetes" with elevated blood sugar	☐ Yes ☐ No
Parathyroid	☐ Yes ☐ No	Gout	☐ Yes ☐ No
Elevated cholesterol	☐ Yes ☐ No	Endocrine gland tumor	☐ Yes ☐ No
Elevated triglycerides	☐ Yes ☐ No	Cancer of endocrine gland	☐ Yes ☐ No
Low blood sugar	☐ Yes ☐ No	High calcium level	☐ Yes ☐ No
Abnormal facial hair growth	☐ Yes ☐ No	Other_____	☐ Yes ☐ No
Review of Systems: Gastrointestinal			
Heartburn	☐ Yes ☐ No	Black, Tarry Stools	☐ Yes ☐ No
Hiatal Hernia	☐ Yes ☐ No	Rectal Bleeding	☐ Yes ☐ No
Ulcers	☐ Yes ☐ No	Polyps	☐ Yes ☐ No
Diarrhea	☐ Yes ☐ No	Abdominal Pain	☐ Yes ☐ No
Blood in Stool	☐ Yes ☐ No	Enlarged Liver	☐ Yes ☐ No
Change in Bowel Habit	☐ Yes ☐ No	Cirrhosis/Hepatitis	☐ Yes ☐ No
Constipation	☐ Yes ☐ No	Gallbladder Problems	☐ Yes ☐ No
Irritable Bowel	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No
Colitis	☐ Yes ☐ No	Pancreatic Disease	☐ Yes ☐ No
Crohns Disease	☐ Yes ☐ No	Unusual Vomiting	☐ Yes ☐ No
Hemorrhoids	☐ Yes ☐ No	Surgery	☐ Yes ☐ No
Fissures	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Review of Systems: Bladder/Kidney			
Kidney Stones	☐ Yes ☐ No	Burning on Urination	☐ Yes ☐ No
Blood in Urine	☐ Yes ☐ No	Loss of Bladder Control (Leaking Urine)	☐ Yes ☐ No
Prostate Problems	☐ Yes ☐ No	Trouble Starting Urination	☐ Yes ☐ No
Kidney Failure	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Date of your last PSA test (men):	Date _____	Surgery	☐ Yes ☐ No

Review of Systems: Gynecologic/Obstetrics			
Are you pregnant?	☐ Yes ☐ No	Date of Last Menstrual Period:	
Do you plan to have more children?	☐ Yes ☐ No	How many children do you have?	No. _____
Problems Conceiving (Infertility)	☐ Yes ☐ No	How many pregnancies have you had?	No. _____
Menstrual Irregularity	☐ Yes ☐ No	How many miscarriages or abortions have you had?	No. _____
Menstrual Pain	☐ Yes ☐ No	Date of Last Pap Smear (women):	Date _____
Excessively Heavy Periods	☐ Yes ☐ No	When did you start your menses?	Age: _____
Are you post menopausal?	☐ Yes ☐ No	Date of Menopause Onset:	
Uterine/Ovarian Cancer	☐ Yes ☐ No	Surgery	☐ Yes ☐ No
Review of Systems: Musculoskeletal			
Arthritis	☐ Yes ☐ No	Lupus	☐ Yes ☐ No
Neck Pain	☐ Yes ☐ No	Scleroderma	☐ Yes ☐ No
Shoulder Pain	☐ Yes ☐ No	Sciatica	☐ Yes ☐ No
Wrist Pain	☐ Yes ☐ No	Autoimmune Disease	☐ Yes ☐ No
Back Pain	☐ Yes ☐ No	Muscle Pain/Spasms	☐ Yes ☐ No
Hip Pain	☐ Yes ☐ No	Fibromyalgia	☐ Yes ☐ No
Knee Pain	☐ Yes ☐ No	Broken Bones	☐ Yes ☐ No
Ankle Pain	☐ Yes ☐ No	Joint Replacement	☐ Yes ☐ No
Foot Pain	☐ Yes ☐ No	Nerve Injury	☐ Yes ☐ No
Heel Pain	☐ Yes ☐ No	Muscular Dystrophy	☐ Yes ☐ No
Ball of Foot/Toe Pain	☐ Yes ☐ No	Surgery	☐ Yes ☐ No
Plantar Fasciitis	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Carpal Tunnel Syndrome	☐ Yes ☐ No		
Review of Systems: Neurologic			
Migraine Headaches	☐ Yes ☐ No	Pseudotumor Cerebri (loss of vision from high pressure in the brain)	☐ Yes ☐ No
Balance Disturbance	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No
Seizures or Convulsions	☐ Yes ☐ No	Frequency Severe Headaches	☐ Yes ☐ No
Weakness	☐ Yes ☐ No	Knocked Unconscious	☐ Yes ☐ No

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Stroke	☐ Yes ☐ No	Surgery	☐ Yes ☐ No
Alzheimer's	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Review of Systems: Blood			
Anemia (iron deficient)	☐ Yes ☐ No	Superficial Blood Clot in Leg	☐ Yes ☐ No
Anemia (vitamin B12 deficient)	☐ Yes ☐ No	Deep Blood Clot in Leg	☐ Yes ☐ No
HIV	☐ Yes ☐ No	Blood Clot in Lungs (pulmonary embolism)	☐ Yes ☐ No
Low Platelets (thrombocytopenia)	☐ Yes ☐ No	Bleeding Disorder	☐ Yes ☐ No
Lymphoma	☐ Yes ☐ No	Blood Transfusion	☐ Yes ☐ No
Swollen Lymph Nodes	☐ Yes ☐ No	Blood Thinning Medicine Use	☐ Yes ☐ No
Review of Systems: Head and Neck			
Wear Contacts/Glasses	☐ Yes ☐ No	Dentures/Partial	☐ Yes ☐ No
Vision Problems	☐ Yes ☐ No	Oral Sores	☐ Yes ☐ No
Hearing Problems	☐ Yes ☐ No	Hoarseness of Voice	☐ Yes ☐ No
Sinus Drainage	☐ Yes ☐ No	Head/Neck Surgery	☐ Yes ☐ No
Neck Lumps	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Difficulty Swallowing	☐ Yes ☐ No		
Review of Systems: Breast			
Lumps	☐ Yes ☐ No	Nipple Discharge	☐ Yes ☐ No
Pain	☐ Yes ☐ No	Surgery	☐ Yes ☐ No
Fibrocystic Disease	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Review of Systems: Skin			
Rashes under Skin Folds	☐ Yes ☐ No	Frequent Skin Infections	☐ Yes ☐ No
Keloids (excessively raised scars)	☐ Yes ☐ No	Surgery	☐ Yes ☐ No
Poor Wound Healing	☐ Yes ☐ No	Cancer	☐ Yes ☐ No

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Review of Systems: Psychiatric			
Anxiety	☐ Yes ☐ No	Have you been hospitalized for psychiatric problems?	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Have you ever been admitted to a psychiatric hospital?	☐ Yes ☐ No
Anorexia (starvation to control weight)	☐ Yes ☐ No	Have you ever attempted suicide?	☐ Yes ☐ No
Bulimia (vomiting to control weight)	☐ Yes ☐ No	Have you ever been physically abused?	☐ Yes ☐ No
Bipolar Disorder ("manic-depression")	☐ Yes ☐ No	Have you ever been sexually abused?	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Have you ever seen a psychiatrist or counselor?	☐ Yes ☐ No
Drug Dependency	☐ Yes ☐ No	Are you currently seeing a psychiatrist or counselor?	☐ Yes ☐ No
Schizophrenia	☐ Yes ☐ No	Have you ever taken medications for psychiatric problems or for depression?	☐ Yes ☐ No
Other Psychiatric Problems	☐ Yes ☐ No	Have you ever been in a chemical dependency program?	☐ Yes ☐ No
Psychiatrist/Therapist Name			
Psychiatrist/Therapist Address and Phone			

Review of Systems: Constitutional			
Fevers	☐ Yes ☐ No	Weight Loss	☐ Yes ☐ No
Night Sweats	☐ Yes ☐ No	Chronic Fatigue	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Hair Loss	☐ Yes ☐ No

I, _____, certify that all the information in this patient questionnaire is true and complete to the best of my knowledge. I understand that any false or incomplete information may affect the care rendered and advice given by the physician and other healthcare providers. I have read, understand, and agree to the above statements.

Signature: _____ Date: _____