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General Surgery & Utah Lap-Band

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PATIENT INFORMATION

Patient's Name _____ Age: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Phone: _____

INSURANCE

Primary Insurance Name: _____

Address: _____ Phone: _____

ID # _____ Group # _____

Subscriber's Name: _____ Birthdate: _____

Patient's Relationship to Insured: _____

Primary Insurance Name: _____

Address: _____ Phone: _____

ID # _____ Group # _____

Subscriber's Name: _____ Birthdate: _____

Patient's Relationship to Insured: _____

PATIENT QUESTIONNAIRE

The information requested in this questionnaire is very important. To give you the best care and to obtain insurance approval if applicable, please fill out as completely as possible.

In your own words, please describe your condition, how it affects your life, what makes any symptoms worse or better, and what testing was performed:

Your Name: _____ Today's Date: _____

PAST MEDICAL HISTORY

- [ ] Check here if you have no active or past medical history issues

- [ ] Diabetes
- [ ] Acid Reflux
- [ ] High Blood Pressure
- [ ] Chronic Bronchitis
- [ ] Depression
- [ ] Swollen Legs
- [ ] Heart Disease
- [ ] Sleep Apnea
- [ ] Asthma
- [ ] Breast Cancer
- [ ] Emphysema
- [ ] Prostate Cancer
- [ ] Colon Cancer
- [ ] Ovarian Cancer
- [ ] Congestive Heart Failure

Additional Information or other conditions not listed above: _____

_____

_____

SURGICAL HISTORY

- [ ] Check here if you have no previous surgeries or hospitalizations

- [ ] Tonsillectomy
- [ ] Appendectomy
- [ ] Hysterectomy
- [ ] Spleen Removed
- [ ] Part of colon or small intestine removed
- [ ] Ovaries Removed
- [ ] Cesearean Section
- [ ] Spinal Fusion
- [ ] Gallbladder
- [ ] Hernia Repair
- [ ] Organ Transplant
- [ ] Joint Replacement

Additional Information or other surgeries not listed above: _____

_____

_____

FAMILY HISTORY

- ☐ Coronary Artery Disease
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Diabetes
- ☐ Obesity
- ☐ Other

SOCIAL HISTORY

Alcohol Consumption: _____ If yes, explain quantity and frequency: _____

_____

Tobacco Consumption: _____ If yes, explain quantity and frequency: _____

_____

Recreational Drugs: _____ If yes, explain what and frequency: _____

_____

Occupation: _____

Please note any quitting history to the above listed: _____

_____

Please check any item or area that has been or is a concern to you or is a medical/health issue which you have dealt with:

GENERAL

- ☐ Weight Loss or Gain
- ☐ Loss of Appetite
- ☐ Fever
- ☐ Fatigue

SKIN/BREAST

- ☐ Rash
- ☐ Breast Tenderness
- ☐ Nipple Discharge
- ☐ Itching
- ☐ Dry Skin
- ☐ Pigmentation
- ☐ Breast Lump
- ☐ Breast Swelling

EARS/EYES/NOSE/MOUTH/THROAT

- [ ] Headaches
- [ ] Dizziness
- [ ] Light Headedness
- [ ] Tearing
- [ ] Head Injury
- [ ] Vision Change
- [ ] Double Vision
- [ ] Eye Pain
- [ ] Nose Bleeding
- [ ] Hoarse Voice
- [ ] Bleeding Gums
- [ ] Sinus Infection
- [ ] Trouble Hearing
- [ ] Thyroid Mass
- [ ] Neck Stiffness, Pain, or Tenderness

CARDIOVASCULAR

- [ ] Chest Pain
- [ ] Palpitations
- [ ] Short of breath during exertion
- [ ] Fainting
- [ ] Swelling
- [ ] Difficulty breathing when lying down
- [ ] Heart Murmurs
- [ ] Awakening at night with difficulty breathing

RESPIRATORY

- [ ] Pain with Breathing
- [ ] Shortness of Breath
- [ ] Wheezing
- [ ] Cough
- [ ] Coughing Up Blood
- [ ] Recurring Infections
- [ ] Tuberculosis
- [ ] Night Sweats

GASTROINTESTINAL

- [ ] Loss of Appetite
- [ ] Difficulty Swallowing
- [ ] Stomach ache after eating
- [ ] Nausea and Vomiting
- [ ] Vomiting Blood
- [ ] Jaundice
- [ ] Heartburn
- [ ] Diarrhea
- [ ] Abnormal Stools
- [ ] Hemorrhoids
- [ ] Constipation

GENITOURINARY

- [ ] Urgency
- [ ] Frequency
- [ ] Pain with Urination
- [ ] Blood in Urine
- [ ] Excessive Urine
- [ ] Urinary Retention
- [ ] Recurring Infections
- [ ] Kidney Stones
- [ ] Vaginal Discharge
- [ ] Vaginal Bleeding
- [ ] Enlarged Prostate

NEUROLOGIC/PSYCHIATRIC

- [ ] Seizures
- [ ] Paralysis
- [ ] Incoordination
- [ ] Numbness/Tingling
- [ ] Loss of Memory
- [ ] Uncoordinated Movements
- [ ] Tremor
- [ ] Depression
- [ ] Hallucinations
- [ ] Suicidal Thoughts
- [ ] Sensory or Motor Disturbances
- [ ] Anxiety

MUSCOLOSKELATEL

- [ ] Pain
- [ ] Swelling
- [ ] Night Cramps
- [ ] Joint Pain
- [ ] Weakness
- [ ] Muscle Atrophy
- [ ] Limited Range of Motion

VASCULAR

- [ ] Mini Strokes
- [ ] Shortness of Breath
- [ ] Leg cramps when walking
- [ ] Temporary Vision Loss
- [ ] Strokes
- [ ] Difficulty Speaking
- [ ] Non-Healing foot sore
- [ ] Weak or numb one side
- [ ] Pain in calves at rest

ALLERGIC/IMMUOLOGIC/LYMPHATIC/ENDOCRINE

- [ ] Bleeding Tendency
- [ ] Transfusions
- [ ] Heat or cold intolerance
- [ ] Anemia

ALLERGIES

Type in any allergies to medications you have: _____

_____

MEDICATIONS

Type in any medications you are currently taking: _____

_____

_____

_____

DIETARY HISTORY

Approximate age when you first seriously dieted: _____

List the diets and diet programs you have tried:

Program	Date	Duration	Supervised	Max Loss/Regained
☐ Jenny Craig	_____	_____	☐ Yes	_____
☐ Nurti-System	_____	_____	☐ Yes	_____
☐ Weight Watchers	_____	_____	☐ Yes	_____
☐ Optifast	_____	_____	☐ Yes	_____
☐ Medifast	_____	_____	☐ Yes	_____
☐ LA Weight Loss	_____	_____	☐ Yes	_____
☐ Fen/Phen/Redux	_____	_____	☐ Yes	_____
☐ Meridia	_____	_____	☐ Yes	_____
☐ Lindora	_____	_____	☐ Yes	_____
☐ T.O.P.S	_____	_____	☐ Yes	_____
☐ Overeaters Anon	_____	_____	☐ Yes	_____
☐ Accupuncture	_____	_____	☐ Yes	_____
☐ Metabolife	_____	_____	☐ Yes	_____
☐ Atkins Diet	_____	_____	☐ Yes	_____

List any other physician-supervised, self-directed exercising and/or documented weight loss attempts: _____

_____

Your current height: _____ Your current weight: _____

Your lowest point in past 5 years: _____ Age at the time: _____

Highest weight in past 5 years: _____ Age at the time: _____

Thank you for making the time to review your medical and health history.
Sincerely,

Dr. Darrin F. Hansen, MD