

PACIFIC LAPAROSCOPY

SURGERY FOR MORBID OBESITY
ADVANCED LAPAROSCOPIC AND ENDOCRINE SURGERY

John M. Rabkin, MD, FACS
Maria Manigbas, PA-C
Barbara Metcalf, RN, CBN

PATIENT INFORMATION (please print)

SPOUSE OR PARENT INFORMATION

NAME _____
ADDRESS _____

NAME _____
ADDRESS _____

PHONE _____
Cell Phone _____
E-MAIL _____

PHONE _____
E-MAIL _____

DATE OF BIRTH _____
OCCUPATION _____
MARITAL STATUS _____

DATE OF BIRTH _____
OCCUPATION _____
MARITAL STATUS _____

SOCIAL SECURITY # _____
DRIVER'S LICENSE # _____

SOCIAL SECURITY # _____
DRIVER'S LICENSE # _____

EMPLOYER _____
BUSINESS ADDRESS _____

EMPLOYER _____
BUSINESS ADDRESS _____

BUSINESS PHONE _____

BUSINESS PHONE _____

INSURANCE CO. _____
ID # _____
POLICY # _____
GROUP # _____

INSURANCE CO. _____
ID # _____
POLICY # _____
GROUP # _____

DO YOU HAVE MEDICARE COVERAGE? _____

PRIMARY PHYSICIAN _____ PHONE _____
REFERRING PHYSICIAN _____ PHONE _____

HOW DID YOU HEAR ABOUT US? _____

EMERGENCY CONTACT (relative, friend or neighbor)

NAME _____ RELATIONSHIP _____
ADDRESS _____ PHONE _____

COMMERCIAL INSURANCE:

I hereby authorize payment of benefits directly to the attending physician. I hereby authorize the attending physician to release any information acquired in the course of my examination and treatment to permit processing of claims for insurance reimbursement.

A photocopy of this signature is valid as the original.

SIGNATURE OF PATIENT OR REPRESENTATIVE _____
PLEASE PRINT YOUR NAME _____ DATE _____

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NAME _____

TODAY'S DATE _____

HEALTH HISTORY QUESTIONNAIRE

DATE OF BIRTH _____

AGE _____

WEIGHT _____

PLACE OF BIRTH _____

HEIGHT _____

PRIMARY CARE PHYSICIAN

REFERRING PHYSICIAN

NAME _____

NAME _____

ADDRESS _____

ADDRESS _____

PHONE _____

PHONE _____

FAX _____

FAX _____

WEIGHT LOSS HISTORY

At what age did you become obese? _____

What was your lowest adult weight? _____

What was your highest adult weight? _____

What is your desired or goal weight? _____

Please describe your age and situation (major stress, if any) at the onset of your obesity:

Approximate weight:

20 yrs. ago _____ 10 yrs. ago _____ 5 yrs. ago _____ 2 yrs. ago _____

1 yr. ago _____ 6 mos. ago _____

WEIGHT LOSS PROGRAMS/DIETS/MEDICATIONS

Maximum weight lost on **any** program: _____

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Weight Watchers | <input type="checkbox"/> Jenny Craig | <input type="checkbox"/> Atkins Diet |
| <input type="checkbox"/> Slimfast | <input type="checkbox"/> Nutrasystems | <input type="checkbox"/> Weight Mgt. Prog. |
| <input type="checkbox"/> Optifast | <input type="checkbox"/> Medifast | <input type="checkbox"/> Cambridge |
| <input type="checkbox"/> Metabolife | <input type="checkbox"/> Diet Center | <input type="checkbox"/> Meridia |
| <input type="checkbox"/> Phen-Fen | <input type="checkbox"/> Xenical | <input type="checkbox"/> Redux |
| <input type="checkbox"/> Other physician/hospital supervised programs: | _____ | |

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San Francisco, CA 94117

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fax 415-668-2010

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MEDICAL HISTORY *(Please check yes or no)*

YES NO

- | | | | |
|--------------------------|--------------------------|--|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a recent Physical Exam? | If yes, date of exam: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a recent Chest X-ray? | If yes, date of X-ray: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a recent EKG? | If yes, date of X-ray: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a recent Abdominal X-Ray? | If yes, date of EKG: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a recent CT Scan/MRIs? | If yes, date of test: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a recent endoscopy/colonoscopy? | If yes, date of EKG: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had recent blood and urine tests? | If yes, date of test: _____ |

ALLERGIES:

REACTION

Have you had any of the following
obesity-related conditions?

YES NO

- | | | |
|--------------------------|--------------------------|--------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma – Worsening with weight |
| <input type="checkbox"/> | <input type="checkbox"/> | Belching of sour fluid |
| <input type="checkbox"/> | <input type="checkbox"/> | Bulimia/excessive vomiting |
| <input type="checkbox"/> | <input type="checkbox"/> | Coughing or choking at night |
| <input type="checkbox"/> | <input type="checkbox"/> | Daily headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Daytime falling asleep |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression (severe) |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes Mellitus |
| <input type="checkbox"/> | <input type="checkbox"/> | Gallbladder disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Gout |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal/Inguinal Hernia |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn/Esoophagitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Hiatal Hernia |
| <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Leakage of urine |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain/Arthritis in lower back |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain/Arthritis in hips |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain/Arthritis in knees |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain/Arthritis in ankles/feet |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath |
| <input type="checkbox"/> | <input type="checkbox"/> | Rash/Dermatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleep apnea Syndrome |
| <input type="checkbox"/> | <input type="checkbox"/> | Swollen ankles/feet |
| <input type="checkbox"/> | <input type="checkbox"/> | Varicose veins |

Please indicate if you had any of the
Following conditions *at any time*:

YES NO

- | | | |
|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma – Allergy/Childhood |
| <input type="checkbox"/> | <input type="checkbox"/> | Autoimmune Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder/kidney infections |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood transfusions |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Clots |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Colitis/Irritable Bowel |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive/heavy bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Failure |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | Heavy Drinking |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Stones |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Lung disease/pneumonia |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Tumors |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers (Gastrointestinal) |

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NAME _____

(Please check yes or no)

- YES/NO Head and Neck
- Do you have migraine/severe headaches?
 - Do you have severe dizziness?
 - Have you fainted in the past 12 months?
 - Are you generally a nervous person?
 - Do you have an eye disease?
 - Do you wear corrective lenses?
 - Are you hard of hearing?
 - Do you have ringing in your ears?
 - Have you had a recent ear infection?
 - Do you have sinus trouble or allergies?
 - Have you had hoarseness?
 - Do you have trouble swallowing?

 - Does swallowed food come back up?
 - Have you had swollen neck glands?

- Heart and Lungs
- Do you have chest pain with exercise?
 - Do you get short of breath often?
 - Do you have a frequent cough?
 - Do you cough up mucous?
 - Do you have to sleep upright in a chair?
 - Are your ankles often definitely swollen?
 - Do you get leg cramps when walking?
 - Do your feet get cold or numb?
 - Are you bothered by palpitations (pounding of the heart)?

- YES/NO Skin
- Have you had a severe skin rash?
 - Have any moles or growths recently changed in size or bothered you?

- GI tract
- Are you troubled by abdominal pain?
 - Are you troubled by frequent nausea?
 - Are you troubled by vomiting?
 - Have you ever vomited blood?
 - Are you troubled by excessive gas?
 - Are you troubled by frequent diarrhea?
 - Are you troubled by frequent constipation?
 - Do you use laxatives regularly?
 - Do you have hemorrhoids?
 - Have you ever had bloody stools?
 - Have your bowel movements changed recently in size, appearance, frequency?
_____ Number of bowel movements per day.

- GU tract
- Do you have trouble starting the urine?
 - Do you sometimes lose control of urine?
 - Have you passed blood in your urine?
_____ Number of times you urinate at night.
_____ Number of times you urinate during the day.

MEDICATIONS

Daily Aspirin: _____ mg/day Daily Vitamins: _____/day types: _____

Please list any other **medications** you are presently taking:

MEDICATION	DOSAGE	TIME WHEN TAKEN
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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SURGERY

Please list all previous surgeries and hospitalizations:

PROCEDURE/DIAGNOSIS	DATE	HOSPITAL NAME/LOCATION
---------------------	------	------------------------

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

EXERCISE

	YES	NO
Do you enjoy exercising?	<input type="checkbox"/>	<input type="checkbox"/>
Have you exercised regularly in the past?	<input type="checkbox"/>	<input type="checkbox"/>
How often do you exercise presently?	_____ times/week	_____ minutes/session

Have you exercised at any gyms, clubs, or spas, or play on any team sports now or in the past?
If yes, please describe: _____

Are you limited during exercise by shortness of breath, dizziness, or chest discomfort?
If yes, please describe: _____

Are you limited during exercise by joint pain or swelling, muscle pain, back pain, torn ligaments?
If yes, please describe: _____

FOR WOMEN ONLY

Date of last menstrual period: _____

Date of last mammogram: _____

Date of last PAP smear: _____

Number of pregnancies: _____

Number of live births: _____

	YES	NO	
Are you pregnant now?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, due date: _____
Are you using any form of birth control?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what type: _____
Are you taking hormone replacement?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what type: _____
Are your menstrual periods painful?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how often: _____
Are your menstrual periods irregular?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of onset: _____
Have you had hot flashes?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of onset: _____

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HABITS

Are you on a special diet? YES NO If yes, please describe: _____

Have you ever smoked cigarettes? Age started: _____ Age quit: _____

Are you currently a smoker? If yes, packs/day: _____

How much do you consume of the following:

Beer _____ 12 oz cans per week

Tea _____ cups per day

Wine _____ 4 oz glasses per week

Coffee (decaffeinated) _____ cups per day

Liquor _____ 2 oz drinks per week

Coffee (regular) _____ cups per day

Where do you eat most of your meals?

- Home
- Restaurant
- Other (please explain) _____

With whom do you usually eat?

- Alone
- With Family
- Other (please explain) _____

Is any member of your household on a special diet? YES NO

If so, please describe: _____

Who usually prepares the food you eat at home? _____

Please list any discomforts or allergies to foods:

What are some of your favorite foods?

Please explain your usual taste preferences and eating habits (*sweets, salty, binge eater, stress, etc.*)

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FAMILY HISTORY

NAME _____

Please indicate which, if any, of your family members had the following conditions:

	Sibling	Mother	Father	Aunt/Uncle	Grandparent
ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BLEEDING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BLOOD CLOTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CANCER (BREAST)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CANCER (COLON)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CANCER (OTHER)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GALLSTONES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GOUT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OBESITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SLEEP APNEA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

YES NO

Is your father living? If not, cause of and age at death: _____

Is your mother living? If not, cause of and age at death: _____

Please list any family members who are obese and their maximum weight:

GENERAL

	YES	NO
Do you live alone?	<input type="checkbox"/>	<input type="checkbox"/>
Are you responsible for an invalid?	<input type="checkbox"/>	<input type="checkbox"/>
Are you presently involved in any lawsuit related to an injury or operation?	<input type="checkbox"/>	<input type="checkbox"/>
Do you often feel pressed for time?	<input type="checkbox"/>	<input type="checkbox"/>
How often do you wake up in the middle of the night?	_____	
How often does your work leave you feeling exhausted?	_____	
How many times per week do you feel angry or frustrated?	_____	
How did you find out about us?	Education: (check all that apply)	
<input type="checkbox"/> Internet	<input type="checkbox"/>	High school
<input type="checkbox"/> Friend or relative	<input type="checkbox"/>	Some College
<input type="checkbox"/> Patient	<input type="checkbox"/>	Associate's degree
<input type="checkbox"/> Health professional	<input type="checkbox"/>	Bachelor's degree
<input type="checkbox"/> Other _____	<input type="checkbox"/>	Master's degree
		Doctorate

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Household members: *(please include ages)*

Please write about you! *(relationships, marriage, children, etc...)*

How does your family feel about you having this surgery?

Please list your activities *(out of home)*:

Please list major personal interests:

How does your weight affect you socially?

How does your weight affect you physically?

Please list any publications which you frequently read *(magazines, newspapers, etc...)*

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What are your concerns about your own health?

What are your concerns or fears about the surgery?

PATIENT AGREEMENT

IF YOU ARE ACCEPTED FOR SURGERY, THE FOLLOWING ARE VERY IMPORTANT TO MAINTAIN GOOD HEALTH AND TO ACHIEVE THE DESIRED WEIGHT LOSS.

- | | YES | NO |
|--|--------------------------|--------------------------|
| Are you willing to avoid foods and beverages containing sugar? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you willing to never use tobacco products? | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcohol causes gastric irritation and liver damage. After surgery, frequent alcohol consumption is unwise and can be harmful. Are you willing to have no alcohol for at least one year after surgery, and to use alcohol only on a very limited basis thereafter? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you willing to make a commitment for regular lifelong medical follow-up? | <input type="checkbox"/> | <input type="checkbox"/> |

PATIENT SIGNATURE: _____

DATE: _____

NOTE: At the time of your visit it is very helpful to review recent medical evaluations and any laboratory studies which you may have had recently performed. Please bring copies with you or request that they be sent by mail or fax prior to the date scheduled for your consultation.

Thank you