

PACIFIC LAPAROSCOPY *progress notes*

SURGERY FOR MORBID OBESITY
 ADVANCED LAPAROSCOPIC AND ENDOCRINE SURGERY

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

NAME: _____ AGE: _____ DATE: _____

<u>Chief Problem</u>	<u>Pre Surg. Conditions</u>	<u>N/A</u>	<u>Resolved</u>	<u>Better</u>	<u>Same</u>	<u>Worse</u>
_____	Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Consultation / initial visit	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pre-operative visit	GERD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Follow-up	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other _____	Joint Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Surgery Date _____	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pre-op Quality of life (1-10) _____	SOB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Current Quality of life (1-10) _____	Urinary Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much weight have you lost in the last month? _____	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICATIONS

Please List _____

VITAMIN SUPPLEMENTS

(Please indicate brand)
 Calcium Citrate _____
 Iron Brand _____
 Multivitamin _____
 Are you taking them regularly?
 YES NO

<u>AVERAGE DAILY INTAKE</u> (servings)	<u>SYMPTOMS</u>	<u>None</u>	<u>Monthly</u>	<u>Weekly</u>	<u>Daily</u>	<u>Meds</u>
Fresh Fruits _____	Abdominal Pain/Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fruit Juice _____	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dairy (cheese/milk) _____	Incision Discomfort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drinks (with sugar) _____	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water _____	Gas Odor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweets _____	Heartburn/Acid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fats _____	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Protein (grams) _____	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Brkfst _____	Leg Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Lunch _____	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Dinner _____	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
# of Meals/Day _____	Hair thinning/loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
# Bowel Movements _____	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If more than 4/day:						
• High Fat Intake YES NO						
• Lactose Intake YES NO						

EXERCISE

Rare
 3 or less / week
 4 or more / week
 Cardio _____ duration
 Resistance _____ duration

GROUP MEETINGS:

Do you attend? YES NO
 Location: _____
 How often: _____
 Do you get Newsletters by email?
 YES NO
 Email: _____

OFFICE USE ONLY:

BP: _____ P: _____ T: _____ PO2: _____

LABS: _____

CC: _____

HEENT: _____

HEART: _____

LUNG: _____

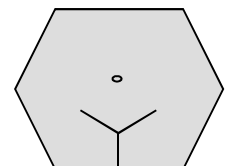
ABD: _____

INCIS: _____

EXT: _____

REC: _____

Height _____
 Pre-op Weight _____
 Pre-Op BMI _____
 Current Weight _____
 Weight Lost _____
 BMI _____
 Pre-op Fat Mass _____
 Current Fat Mass _____
 Pre-op FFM _____
 Current FFM _____
 Pre-op Fat% _____
 Current Fat % _____



MD/PA Signature: _____