

# PACIFIC LAPAROSCOPY progress notes

SURGERY FOR MORBID OBESITY  
 ADVANCED LAPAROSCOPIC AND ENDOCRINE SURGERY

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NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_

Chief Problem	Pre Surg. Conditions	N/A	Resolved	Better	Same	Worse
_____	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 Weight _____	SOB	<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? _____	Urinary Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	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

**AVERAGE DAILY INTAKE (servings)**

Fresh Fruits \_\_\_\_\_  
 Fruit Juice \_\_\_\_\_  
 Dairy (cheese/milk) \_\_\_\_\_  
 Drinks (with sugar) \_\_\_\_\_  
 Water \_\_\_\_\_  
 Sweets \_\_\_\_\_  
 Fats \_\_\_\_\_  
 Protein (grams) \_\_\_\_\_  
 • Brkfst \_\_\_\_\_  
 • Lunch \_\_\_\_\_  
 • Dinner \_\_\_\_\_  
 # of Meals/Day \_\_\_\_\_  
 # of Bowel Movements \_\_\_\_\_  
 If more than 4/day:  
 • High Fat Intake  YES  NO  
 • Lactose Intake  YES  NO

**SYMPTOMS**

	None	Monthly	Weekly	Daily	Meds
Abdominal Pain/Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incision Discomfort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gas Odor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn/Acid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leg Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair thinning/loss	<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"/>

**EXERCISE**

Rare  
 3 or less / week  
 4 or more / week  
 Cardio \_\_\_\_\_ duration  
 Resistance \_\_\_\_\_ duration

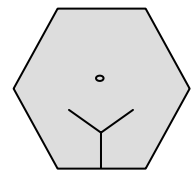
**GROUP MEETINGS:**

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: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Current Weight \_\_\_\_\_  
 Weight Lost \_\_\_\_\_  
 BMI \_\_\_\_\_  
 Pre-op Fat Mass \_\_\_\_\_  
 Current Fat Mass \_\_\_\_\_  
 Pre-op FFM \_\_\_\_\_  
 Current FFM \_\_\_\_\_



MD/PA Signature: \_\_\_\_\_