



## Minimally Invasive Gastrointestinal Surgery Center

### Section 4. Medical History (please check off any problems you have or answer "none of the above")

<p><b>Blood Vessels &amp; Heart</b></p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Irregular heart beat (afib or WPW)</p> <p><input type="checkbox"/> Bleeding problem</p> <p><input type="checkbox"/> Blood clots or DVT</p> <p><input type="checkbox"/> Chest pain (Angina)</p> <p><input type="checkbox"/> Heart disease</p> <p><input type="checkbox"/> Cardiomyopathy</p> <p><input type="checkbox"/> Congestive heart failure</p> <p><input type="checkbox"/> Heart attack (MI)</p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> High cholesterol</p> <p><input type="checkbox"/> High triglycerides</p> <p><input type="checkbox"/> Diseased leg arteries (PVD)</p> <p><input type="checkbox"/> Diseased neck arteries (carotids)</p> <p><input type="checkbox"/> No heart or blood vessel problems</p> <p><b>Prior Heart Procedures</b></p> <p><input type="checkbox"/> Cardiac catheterization (angioplasty)</p> <p><input type="checkbox"/> Heart Bypass</p> <p><input type="checkbox"/> No heart procedures</p> <p><b>Liver, Stomach, and Intestine</b></p> <p><input type="checkbox"/> Gallstones</p> <p><input type="checkbox"/> Inflamed or diseased gallbladder</p> <p><input type="checkbox"/> Gallstone caused pancreatitis or blocked duct</p> <p><input type="checkbox"/> Fatty liver (NASH)</p> <p><input type="checkbox"/> Hepatitis (type: _____)</p> <p><input type="checkbox"/> Reflux or heartburn (GERD)</p> <p><input type="checkbox"/> Bile reflux</p> <p><input type="checkbox"/> Hiatal hernia</p> <p><input type="checkbox"/> Barrett's esophagus</p> <p><input type="checkbox"/> Schatzki's ring</p> <p><input type="checkbox"/> Stomach or intestinal ulcer</p> <p><input type="checkbox"/> Crohn's disease</p> <p><input type="checkbox"/> Ulcerative colitis</p> <p><input type="checkbox"/> Colon cancer</p> <p><input type="checkbox"/> Fecal incontinence</p> <p><input type="checkbox"/> Irritable bowel disorder</p> <p><input type="checkbox"/> Hernia</p> <p style="margin-left: 20px;">Incisional (ventral):    <input type="checkbox"/> yes    <input type="checkbox"/> no</p> <p style="margin-left: 20px;">Umbilical:                    <input type="checkbox"/> yes    <input type="checkbox"/> no</p> <p style="margin-left: 20px;">Non-reducible:            <input type="checkbox"/> yes    <input type="checkbox"/> no</p> <p><input type="checkbox"/> No stomach or intestinal disorders</p>	<p><b>Lungs &amp; Breathing</b></p> <p><input type="checkbox"/> Asthma?</p> <p style="margin-left: 20px;">Age of onset: _____ years old</p> <p style="margin-left: 20px;">Hospitalized:            <input type="checkbox"/> yes    <input type="checkbox"/> no</p> <p style="margin-left: 20px;">Last episode: month: ____ year: _____</p> <p><input type="checkbox"/> Home oxygen use?</p> <p><input type="checkbox"/> Obstructive Sleep apnea</p> <p style="margin-left: 20px;">Do you use CPAP?        <input type="checkbox"/> yes    <input type="checkbox"/> no</p> <p style="margin-left: 20px;">CPAP setting? _____</p> <p style="margin-left: 20px;">Last episode: _____</p> <p><input type="checkbox"/> Pulmonary embolus (blood clot in lung)</p> <p><input type="checkbox"/> Pulmonary hypertension</p> <p><input type="checkbox"/> COPD (emphysema or chronic bronchitis)</p> <p><input type="checkbox"/> No lung or breathing problems</p> <p><b>Joints</b></p> <p><input type="checkbox"/> Low back pain (lumbosacral)</p> <p><input type="checkbox"/> Neck pain (cervical)</p> <p><input type="checkbox"/> Osteoarthritis</p> <p><input type="checkbox"/> Degenerative joint disease (DJD)</p> <p><input type="checkbox"/> Degenerative disk disease (DDD)</p> <p><input type="checkbox"/> Herniated disk</p> <p><input type="checkbox"/> Gout</p> <p><input type="checkbox"/> Carpal tunnel syndrome</p> <p><input type="checkbox"/> Sciatica</p> <p><input type="checkbox"/> Plantar fasciitis</p> <p><input type="checkbox"/> No joint problems</p> <p><b>Neurological</b></p> <p><input type="checkbox"/> CVA / stroke</p> <p><input type="checkbox"/> Pseudotumor cerebri</p> <p><input type="checkbox"/> Narcolepsy</p> <p><input type="checkbox"/> Neuropathy</p> <p><input type="checkbox"/> Migraine headaches</p> <p><input type="checkbox"/> No neurological problems</p> <p><b>Psychological</b></p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Bipolar disorder</p> <p><input type="checkbox"/> Schizophrenia</p> <p><input type="checkbox"/> Prior psychiatric hospitalization</p> <p><input type="checkbox"/> No psychological problems</p>	<p><b>Endocrine (hormone)</b></p> <p><input type="checkbox"/> Glucose intolerance / borderline diabetes</p> <p><input type="checkbox"/> Diabetes type II</p> <p style="margin-left: 20px;">Duration: _____ years</p> <p style="margin-left: 20px;">Insulin requiring:    <input type="checkbox"/> yes    <input type="checkbox"/> no</p> <p style="margin-left: 20px;">Oral agent:                <input type="checkbox"/> yes    <input type="checkbox"/> no</p> <p style="margin-left: 20px;">Diet controlled:        <input type="checkbox"/> yes    <input type="checkbox"/> no</p> <p style="margin-left: 20px;">Recent HbA1c (%): _____</p> <p><input type="checkbox"/> Diabetes nerve problems</p> <p><input type="checkbox"/> Diabetes retinopathy</p> <p><input type="checkbox"/> Diabetic ulcers</p> <p><input type="checkbox"/> Infertility</p> <p><input type="checkbox"/> Polycystic Ovary Syndrome (PCOS)</p> <p><input type="checkbox"/> Low thyroid level (hypothyroid)</p> <p><input type="checkbox"/> Hypoglycemia</p> <p><input type="checkbox"/> Metabolic syndrome</p> <p><input type="checkbox"/> Morbid obesity</p> <p><input type="checkbox"/> No hormone problems</p> <p><b>Kidneys &amp; Genito-Urinary</b></p> <p><input type="checkbox"/> Kidney infection</p> <p><input type="checkbox"/> Kidney stone (s)</p> <p><input type="checkbox"/> Kidney failure</p> <p style="margin-left: 20px;"><input type="checkbox"/> diabetic or <input type="checkbox"/> other</p> <p><input type="checkbox"/> Frequent bladder infections (UTI's)</p> <p><input type="checkbox"/> Enlarged prostate</p> <p><input type="checkbox"/> Prostate cancer</p> <p><input type="checkbox"/> Impotence</p> <p><input type="checkbox"/> Urinary stress incontinence</p> <p><input type="checkbox"/> Prolapsed bladder</p> <p><input type="checkbox"/> None of the above</p> <p><input type="checkbox"/> N/A</p> <p><b>Skin</b></p> <p><input type="checkbox"/> Skin fold rashes</p> <p><input type="checkbox"/> Skin infection (cellulitis)</p> <p><input type="checkbox"/> Lymphedema (leg swelling)</p> <p><input type="checkbox"/> None of the above</p> <p><b>Other</b></p> <p><input type="checkbox"/> Please see detail below for other conditions</p>
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**Please provide detail of medical history marked positive above or describe any unlisted conditions:**

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## Minimally Invasive Gastrointestinal Surgery Center

### Section 5. Surgical History (please check boxes and provide dates)

Operation	Laparoscopic or Open	Year
<input type="checkbox"/> I have never had surgery		
<input type="checkbox"/> Gallbladder removal?	<input type="checkbox"/> lap <input type="checkbox"/> open	_____
<input type="checkbox"/> C-Section?		_____
<input type="checkbox"/> Appendix removal?	<input type="checkbox"/> lap <input type="checkbox"/> open	_____
<input type="checkbox"/> Hysterectomy (Uterus removal)?		_____
<input type="checkbox"/> Transvaginal or <input type="checkbox"/> Abdominal		
Which ovary was removed?	<input type="checkbox"/> Both <input type="checkbox"/> Left <input type="checkbox"/> Right	
<input type="checkbox"/> Tubal ligation ("tubes tied")?	<input type="checkbox"/> lap <input type="checkbox"/> open	_____
<input type="checkbox"/> Hernia repair?		_____
Was mesh placed? <input type="checkbox"/> yes <input type="checkbox"/> no		
<input type="checkbox"/> Bowel surgery (colon or small intestine)	<input type="checkbox"/> lap <input type="checkbox"/> open	_____
<input type="checkbox"/> Plastic surgery (abdominal)		_____
<input type="checkbox"/> Weight loss surgery		_____
<input type="checkbox"/> Other surgery		_____
Please describe additional surgery:	_____	
<b>Surgical or anesthesia problems</b>	Details	
<input type="checkbox"/> Nausea and/or vomiting	_____	
<input type="checkbox"/> Malignant hyperthermia	_____	
<input type="checkbox"/> Bleeding tendency	_____	
<input type="checkbox"/> Difficult Intubation	_____	
<input type="checkbox"/> Complications after surgery	_____	

### Section 6. OB/GYN History (women only)

<b>Menstrual history:</b>
Length of cycles: _____ days
Length of periods: _____ days
At what age did menstruation start? _____
Have you stopped menstruating? <input type="checkbox"/> Yes <input type="checkbox"/> No
Hot flushes or night sweats? <input type="checkbox"/> Yes <input type="checkbox"/> No
Last menstrual period normal? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Obstetric history:</b>
Is it possible you are pregnant now <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you plan more pregnancies? <input type="checkbox"/> Yes <input type="checkbox"/> No
How many children do you have? _____
How old are they? _____
How many pregnancies? _____
What do you use for birth control? _____
<b>Gynecologic history:</b>
When was your last PAP/pelvic exam? _____
Abnormal PAPs? <input type="checkbox"/> Yes <input type="checkbox"/> No
STD's or pelvic inflammatory disease? <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer of ovary or uterus? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Sexual history:</b>
How often do you have sexual intercourse? _____ times per <input type="checkbox"/> month or per <input type="checkbox"/> year
Do you have pelvic pain or other pain with intercourse? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Breast history:</b>
Have you had a mammogram? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had breast cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No

### Section 7. Social History (please answer or write "none")

Occupation: _____ Support system: <input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Children <input type="checkbox"/> Parents <input type="checkbox"/> Other _____ Do you smoke now? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever smoked? <input type="checkbox"/> Yes <input type="checkbox"/> No Started at what age?: _____ Stopped at what age?: _____ Packs per day?: _____	How many alcoholic beverages do you drink? _____ per day _____ per week Do you use marijuana? <input type="checkbox"/> Yes <input type="checkbox"/> No How Often? _____ Do you use illegal drug substances? <input type="checkbox"/> Yes <input type="checkbox"/> No Please provide details _____
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### Section 8. Family History (please check problems that run in your family)

<input type="checkbox"/> Obesity <input type="checkbox"/> Bleeding Problems <input type="checkbox"/> Heart Disease <input type="checkbox"/> Cancer (location: _____) <input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Blood Clots (in the legs or to the lungs) <input type="checkbox"/> Other: _____	Is your mother alive? <input type="checkbox"/> Yes <input type="checkbox"/> No If deceased, from what cause? _____ Is your father alive? <input type="checkbox"/> Yes <input type="checkbox"/> No If deceased, from what cause? _____ Is your sister(s) alive? <input type="checkbox"/> Yes <input type="checkbox"/> No If deceased, from what cause? _____ Is your brother(s) alive? <input type="checkbox"/> Yes <input type="checkbox"/> No If deceased, from what cause? _____
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## Minimally Invasive Gastrointestinal Surgery Center

### Section 9. Medications (please list all medications including doses and frequency; include herbal supplements)

Drug	Dose	How often each day?	Year Started
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____
9. _____	_____	_____	_____
10. _____	_____	_____	_____
11. _____	_____	_____	_____
12. _____	_____	_____	_____
13. _____	_____	_____	_____
14. _____	_____	_____	_____
15. _____	_____	_____	_____

### Section 10. Allergies and Restrictions (please list)

**Drug Allergies**  
 I have no drug allergies  
Drug \_\_\_\_\_ Reaction \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Contact Allergies**  
 Latex       Adhesive tape

**Food Allergies**  
 I have no food allergies  
Food \_\_\_\_\_ Reaction \_\_\_\_\_  
\_\_\_\_\_

**Dietary Restrictions**  
 I have no dietary restrictions  
Vegetarian?       Yes    No  
Vegan?             Yes    No  
Kosher?             Yes    No  
Lactose Intolerant?    Yes    No  
Other restrictions?    Yes    No

### Section 11. Diagnostic Procedures (please check off any recent diagnostic procedures that you have had or answer "none of the above")

Test	Date	Location (which hospital or clinic)	Reason
<input type="checkbox"/> EKG	_____	_____	_____
<input type="checkbox"/> Stress Test	_____	_____	_____
<input type="checkbox"/> Lower GI	_____	_____	_____
<input type="checkbox"/> Colonoscopy	_____	_____	_____
<input type="checkbox"/> CT scan	_____	_____	_____
<input type="checkbox"/> Chest x-ray	_____	_____	_____
<input type="checkbox"/> Heart Catheterization	_____	_____	_____
<input type="checkbox"/> Upper Endoscopy	_____	_____	_____
<input type="checkbox"/> Sleep Study	_____	_____	_____
<input type="checkbox"/> Echocardiogram	_____	_____	_____
<input type="checkbox"/> Upper GI	_____	_____	_____
<input type="checkbox"/> Abdominal ultrasound	_____	_____	_____
<input type="checkbox"/> Pulmonary Function Test	_____	_____	_____
<input type="checkbox"/> Blood Work	_____	_____	_____

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## Minimally Invasive Gastrointestinal Surgery Center

**Section 12. Review of Systems (please check off any symptoms you have or answer "none of the above" for each group)**

<p><b>General</b></p> <input type="checkbox"/> Weakness <input type="checkbox"/> Fatigue <input type="checkbox"/> Night sweats <input type="checkbox"/> Recent weight change <input type="checkbox"/> None of the above	<p><b>Pulmonary</b></p> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Productive cough <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Nighttime snoring <input type="checkbox"/> Loud snoring <input type="checkbox"/> None of the above	<p><b>Neurological</b></p> <input type="checkbox"/> Seizures <input type="checkbox"/> Migraine headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Loss of balance <input type="checkbox"/> Numbness/tingling <input type="checkbox"/> None of the above
<p><b>Skin</b></p> <input type="checkbox"/> Skin cancer <input type="checkbox"/> Skin fold rashes (groin or other folds) <input type="checkbox"/> Pigment changes <input type="checkbox"/> Jaundice (yellow skin) <input type="checkbox"/> Varicose veins <input type="checkbox"/> Leg ulcer(s) <input type="checkbox"/> None of the above	<p><b>Gastrointestinal</b></p> <input type="checkbox"/> Nausea (frequency: _____) <input type="checkbox"/> Vomiting (frequency: _____) <input type="checkbox"/> Diarrhea (frequency: _____) <input type="checkbox"/> Constipation <input type="checkbox"/> Ulcers (date: _____) <input type="checkbox"/> Difficulty swallowing (food gets stuck) <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Reflux / heartburn <input type="checkbox"/> Vomiting blood <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> None of the above	<p><b>Psychological</b></p> <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Hallucinations <input type="checkbox"/> None of the above
<p><b>HEENT</b></p> <input type="checkbox"/> Vision changes <input type="checkbox"/> Hearing changes <input type="checkbox"/> Headaches <input type="checkbox"/> Lightheadness <input type="checkbox"/> None of the above	<p><b>Genitourinary</b></p> <input type="checkbox"/> Pain/burning with urination <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Blood in urine <input type="checkbox"/> Urinary incontinence <input type="checkbox"/> Kidney stones <input type="checkbox"/> Urinary tract infection <input type="checkbox"/> None of the above	<p><b>Female</b>    <input type="checkbox"/> N/A</p> <input type="checkbox"/> Loss of menstrual cycles <input type="checkbox"/> Excessive menstrual bleeding <input type="checkbox"/> Irregular menstrual cycles <input type="checkbox"/> Postmenopausal bleeding <input type="checkbox"/> Vaginal discharge or itching <input type="checkbox"/> Genital Sores/Lesions <input type="checkbox"/> Sexually Transmitted Diseases (STDs) <input type="checkbox"/> PID (Pelvic Inflammatory Disease) <input type="checkbox"/> None of the above
<p><b>Neck</b></p> <input type="checkbox"/> Pain <input type="checkbox"/> Masses <input type="checkbox"/> None of the above	<p><b>Hematological</b></p> <input type="checkbox"/> History of blood transfusions <input type="checkbox"/> Bleeding problems <input type="checkbox"/> Clotting problems <input type="checkbox"/> Superficial blood clots <input type="checkbox"/> None of the above	<p><b>Male</b>    <input type="checkbox"/> N/A</p> <input type="checkbox"/> Penile discharge <input type="checkbox"/> Genital sores/lesions <input type="checkbox"/> Testicular pain or lumps <input type="checkbox"/> Sexually Transmitted Diseases (STDs) <input type="checkbox"/> Impotence <input type="checkbox"/> Hernias <input type="checkbox"/> None of the above
<p><b>Musculoskeletal</b></p> <input type="checkbox"/> Hip pain <input type="checkbox"/> Knee pain <input type="checkbox"/> Ankle or foot pain <input type="checkbox"/> Back pain <input type="checkbox"/> Wrist pain <input type="checkbox"/> Shoulder pain <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Arthritis <input type="checkbox"/> Swelling of legs <input type="checkbox"/> None of the above	<p><b>Endocrine</b></p> <input type="checkbox"/> Intolerance to hot or cold <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid problems <input type="checkbox"/> None of the above	
<p><b>Cardiovascular</b></p> <input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Shortness of breath <input type="checkbox"/> None of the above		

**Please provide detail of symptoms marked positive above:**

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