



Lutheran Medical Center
Surgical Weight Loss Institute.

George S. Ferzli, M.D. F.A.C.S
Corneliu T. Vulpe, M.D.

CLINICAL HISTORY FORM

Last Name _____ First Name _____ MI _____ Date _____

General History

Gender Male Female Date of Birth _____ Age _____

Height _____ Weight _____

Which procedure are you interested in?

Roux en Y (Gastric Bypass) Adjustable Lap Band

Age of obesity onset.

0-2 years 2-12 years 12-18 years 20's Pregnancy Middle Age

How many years have you been at your present weight? _____

Were there any significant events that lead to your weight gain?

Loss of a loved one Pregnancy Other _____
 Divorce Trauma, Accident or _____
 Loss of employment Illness, describe _____
 Depression _____

What is the most weight you have lost? _____ pounds

How long did you keep it off? _____

Do you smoke? Yes, how many cigarettes per day _____
 Quit, when _____
 Never

Do you have a history of, or presently use recreational drugs?

Yes No, describe _____

Do you drink alcoholic beverages? No Yes

If yes, Daily Weekly Monthly On occasions Never

Physical History

Do you have any of the following diagnoses, conditions, symptoms?
If so, please place a check in the box.

Endocrinology

- Diabetes insulin dependant
- Diabetes non-insulin dependant
- Hyperthyroid
- Hypothyroid
- Goiter
- Graves Disease

Neurology

- Numbness/tingling of feet or hands
- Seizures
- Epilepsy
- Stroke/TIA

Skin

- Dermatitis
- Rashes
- Open sores
- Psoriasis

Vascular

- Anemia
- Thrombocytopenia/low platelets
- Blood clot (s) in leg
- Pulmonary embolism
- Problems with Circulation in the legs
- Swelling of the legs
- Peripheral vascular disease

OB/GYN

- Irregular Periods
- Difficulty getting pregnant
- Excessively Painful Periods
- Fibroids
- Ovarian cysts

Number of children _____

Number of pregnancies _____

Date of last mammogram _____

Date of last Pap Smear _____

Gastrointestinal

- Migraine headaches
- Gout
- Pain in weight-bearing joints
- Fibromyalgia

- GERD (reflux disease)
- Heartburn
- Stomach Ulcer
- Duodenal Ulcer
- Constipation
- Diarrhea
- Vomiting
- Difficulty swallowing
- Rectal bleeding
- Abdominal pain
- Colitis
- Irritable Bowel Syndrome
- Crohn's Disease
- Gallbladder Disease
- Gallstones

Respiratory

- COPD
(Chronic Obstructive Pulmonary Disease)
- Emphysema
- Asthma or Chronic Bronchitis
- Sleep Apnea
- Shortness of breath upon exertion
- Snoring

Cardiovascular

- Angina
- Palpitations
- Chest pain
- Blood clots (due to injury or surgery):
- Heart Attack
- Cardiomyopathy
- Congestive heart failure
- High cholesterol or Triglycerides

Infectious Disease

- Hepatitis (A, B or C):
- Cirrhosis
- HIV Positive
- Other, _____

Genito-Urinary

- Recurrent urinary tract infections
- Kidney stones
- Kidney disease
- Kidney failure (dialysis)
- Stress incontinence/ urinary frequency

Musculoskeletal

- Arthritis
- Back Pain

Psychological

- Depression
- Schizophrenia
- Bi-Polar Disorder
- Anxiety
- Suicide attempt
- Anorexia
- Bulimia

Please provide any other information you feel is pertinent which will help the doctor treat you:

Medications / Supplements / Herbs Use

List in the table below anything you are currently taking on a regular basis:
(Make sure to include the following: aspirin, Heparin, Coumadin, Plavix, and Vitamin K)

Name of Item	Dose	Frequency	Start date	What is the reason for taking this?	Was this ordered by a doctor / who?

When was the date of your last physical exam and who is your doctor?

Major Medical History

Illness	Treatment	Date	Doctor

Surgical History

Procedure	Date

Have you experienced any problems associated with a surgery?

If so place a check in the box and briefly describe.

- Anesthesia, describe _____
- Infected wound, describe _____
- Bleeding, describe _____
- Clotting, describe _____
- Fever, describe _____
- Difficulty healing, describe _____
- Other _____, describe _____

Medical Family History

Does anyone in your family have/had the following?

If so, please place a check in the box and list who (sibling, parent, and/or grandparent).

- Obesity, who _____
- Hypertension, who _____
- Diabetes, who _____
- Cardiac problems/ Heart disease, who _____
- Stroke, who _____
- Lung disease, who _____
- Liver disease, who _____
- Arthritis, who _____
- Cancer, who _____
- Blood clots, who _____
- Early death, who and describe _____

Allergies

Are you allergic to any medications? YES NO

Medication _____ Reaction _____

Medication _____ Reaction _____

Are you allergic to any foods? YES NO

Food _____ Reaction _____

Food _____ Reaction _____

Are you allergic to any materials? YES NO (ex. Latex, Iodine, surgical tape)

Material _____ Reaction _____

Material _____ Reaction _____

Medically Supervised Diets

PLEASE SUPPLY AS MUCH INFORMATION AS POSSIBLE					
	Dr. / Clinic	Year	Duration	Pounds lost	Pounds regained
In-Patient Programs					
Rader Institute					
Other:					
Other:					
Supervised Outpatient					
Opti-Fast					
Medi-Fast					
Registered Dietitian					
Prescription Diets					
Meridia					
Amphetamines					
Phen-Fen					
Fastina					
Xenical					
Lonomin					
Didrex					
Phentermine					
Pondimine					
Redux					
Paxil					
Wellbutrin					
Celexa					
Prozac					
Sarafen					
Lasix					
Adipex					
HcG/13-6/13-12					

Shots					
Reduced Calorie Diets					
1,000 Cal/day					
1,200 Cal/day					
1,500 Cal/day					
2,200 Cal/day					
Other:					
Limited Intake					
Lo Cholesterol					
Lo Carb					
Alternative Therapies					
Gastric Bubble					
Hypnosis					
Jaw Wiring					
Acupuncture					

Non-Medically Supervised Weight Loss Methods

Please place a check in the box if you have tried any of the following.

- | | | |
|--|--|--|
| <input type="checkbox"/> Jenny Craig
<input type="checkbox"/> Acutrim
<input type="checkbox"/> 24 Hr Fitness
<input type="checkbox"/> Nutri/System
<input type="checkbox"/> Dexatrim
<input type="checkbox"/> Lydia's Health Spa
<input type="checkbox"/> Weight Watcher's
<input type="checkbox"/> Diuerex
<input type="checkbox"/> Curves
<input type="checkbox"/> TOPS
<input type="checkbox"/> Xenadrine
<input type="checkbox"/> LA Fitness
<input type="checkbox"/> Over Eater's
Anonymous
<input type="checkbox"/> Herbal Phen/Fen
<input type="checkbox"/> California Fitness
<input type="checkbox"/> Loma Linda Med. Ctr.
<input type="checkbox"/> Metabolife
<input type="checkbox"/> Sports Center
<input type="checkbox"/> (Rotation or Cabbage
<input type="checkbox"/> Metabolite
<input type="checkbox"/> Richard Simmons Deal-A-Meal | <input type="checkbox"/> Family Fitness
<input type="checkbox"/> Imperial Fitness
<input type="checkbox"/> Mayo Clinic Diet
<input type="checkbox"/> New Dimensions
<input type="checkbox"/> Cambridge diet
<input type="checkbox"/> American Health Spa
<input type="checkbox"/> Venus Di Milo Gym
<input type="checkbox"/> World Gym
<input type="checkbox"/> Susan Powter
<input type="checkbox"/> Rich Simmons Tape
<input type="checkbox"/> Vic Tanny Fitness
<input type="checkbox"/> South Beach Diet
<input type="checkbox"/> Denise Austin
Workout
<input type="checkbox"/> YMCA
<input type="checkbox"/> Slim Fast
<input type="checkbox"/> Jane Fonda Workout
<input type="checkbox"/> Slender Lady Spa
<input type="checkbox"/> Weigh Down Diet
<input type="checkbox"/> Jazzercise Tapes
<input type="checkbox"/> Sports Plus
<input type="checkbox"/> Sweet Success | <input type="checkbox"/> Aerobics Tapes
<input type="checkbox"/> Fitness USA
<input type="checkbox"/> Sugar Busters Diet
<input type="checkbox"/> Dance Tapes
<input type="checkbox"/> Slim Down Express
<input type="checkbox"/> The Anti-Diet
<input type="checkbox"/> Tae Bo Tapes
<input type="checkbox"/> Ladies Spa
<input type="checkbox"/> CA Slim
<input type="checkbox"/> Dance Classes
<input type="checkbox"/> Bally's Super Centers
<input type="checkbox"/> Super Dieter's Tea
<input type="checkbox"/> Exercise Classes
<input type="checkbox"/> Beverly Hills diet
<input type="checkbox"/> Personal Trainer
<input type="checkbox"/> BioSlim
<input type="checkbox"/> Home gym
<input type="checkbox"/> Herbalife
<input type="checkbox"/> Fasting
<input type="checkbox"/> Hollywood 24-Hour
<input type="checkbox"/> Body Solutions |
|--|--|--|