SOUTH TEXAS SURGEONS PROFESSIONAL ASSOCIATION

General and Laparoscopic Surgery — Surgical Treatment of Obesity

Gerardo E. Cárcamo, M.D — J. Keith Wright, M.D.

PATIENT MEDICAL HISTORY

NAME: **DOB:** **AGE:**

MARITAL STATUS: ☐ S ☐ M ☐ D ☐ W **PRIMARY CARE PHYSICIAN (PCP):**

REFERRING PHYSICIAN: ☐ My PCP or **Name:** _____

REASON FOR CONSULTATION: _____

Interested in Weight Loss Surgery: ☐ LAP BAND ☐ SLEEVE GASTRECTOMY ☐ GASTRIC BYPASS

PLEASE LIST YOUR CHRONIC MEDICAL PROBLEMS:

☐ DIABETES ☐ HIGH BLOOD PRESSURE ☐ HIGH CHOLESTEROL ☐ OBESITY ☐ SLEEP APNEA
☐ GERD ☐ HEART DISEASE ☐ HEART ATTACK ☐ CONGESTIVE HEART FAILURE
☐ STROKE ☐ BLOOD CLOTS (DVT) ☐ ASTHMA ☐ COPD ☐ THYROID:
☐ CANCER ☐ OTHER: _____

LIST ALL OPERATIONS/SURGERIES TO INCLUDE ANY PREVIOUS BARIATRIC SURGERY:

Can you walk without getting short of breath? ☐ YES ☐ NO
How far can you walk before getting short of breath? _____
Can you walk up stairs? ☐ YES ☐ NO **How many stairs can you walk?** _____
Do you get chest pain when you walk and/or do strenuous activities? ☐ YES ☐ NO

LIST ANY DRUG ALLERGIES: ☐ **(NKDA) NO KNOWN DRUG ALLERGIES:**

Are you allergic to Latex? ☐ YES ☐ NO
DO YOU CURRENTLY TAKE?: ☐ ASPIRIN ☐ COUMADIN ☐ PREDNISONE OR STEROIDS ☐ MEDICATIONS THAT CAUSE BLEEDING

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

NAME OF MEDICATION & DOSE	NAME OF MEDICATION & DOSE	NAME OF MEDICATION & DOSE

_____ **I give my permission to allow South Texas Surgeons to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers. (Please initial.)**

SOCIAL HISTORY

OCCUPATION:

Do you drink alcohol? ☐ No ☐ Yes, how often? _____ How much? _____

Do you smoke cigarettes: ☐ Never ☐ Quit: Date_____ ☐ Current, #packs/day_____ # of yrs _____
Other Tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew Usage: _____

Do you use any recreational drugs? ☐ No ☐ Yes If yes, what kind? _____ How much? _____

FAMILY HISTORY

Obesity: ☐ mother ☐ father ☐ brother/sister **Cancer:** ☐ mother ☐ father ☐ brother/sister

Other:

11212 State Hwy 151 Plaza 2, Suite 201 • San Antonio, Texas 78251 • (210) 703-9440 • Fax (210) 520-0378
www.stxsurgeons.com

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(*PATIENT MEDICAL HISTORY CONINTUED:* **BOTH CURRENT AND OLD PROBLEMS**)

	Y	N	SYMPTOM	DESCRIBE
NEURO	☐	☐	CONVULSIONS	
	☐	☐	MIGRAINE HEADACHES	
	☐	☐	STROKES	
	☐	☐	PARALYSIS	
CARDIAC	☐	☐	CHEST PAIN	
	☐	☐	SHORTNESS OF BREATH	
	☐	☐	HIGH BLOOD PRESSURE	
	☐	☐	HEART FAILURE	
	☐	☐	HEART ATTACK	
PULMONARY	☐	☐	CHRONIC COUGH	
	☐	☐	SLEEP APNEA / SNORING	
	☐	☐	ASTHMA	
	☐	☐	RECENT COLDS OR PNEUMONIA	
RENAL	☐	☐	BLOOD IN URINE	
	☐	☐	FREQUENT BLADDER INFECTIONS	
	☐	☐	KIDNEY INFECTIONS/DISORDERS	
	☐	☐	PAIN WHEN URINATING	
GASTROINTESTINAL	☐	☐	BLOOD IN STOOL	
	☐	☐	VOMITING BLOOD	
	☐	☐	BLACK STOOLS	
	☐	☐	CHRONIC DIARRHEA	
	☐	☐	CHRONIC CONSTIPATION	
	☐	☐	BLOATING	
	☐	☐	NAUSEA OR VOMITING	
	☐	☐	DIFFICULTY SWALLOWING	
	☐	☐	PAIN WHEN SWALLOWING	
	☐	☐	CHRONIC HEARTBURN / REFLUX	
	☐	☐	HEPATITIS	CIRCLE ONE YOU HAD/HAVE: A B C DONT KNOW
	☐	☐	STOMACH OR INTESTINAL ULCERS	
	☐	☐	PANCREATITIS	
	☐	☐	GALLSTONES	REMOVED? YES NO
ENDOCRINE	☐	☐	DIABETES	
	☐	☐	THYROID PROBLEMS	
	☐	☐	LACK OF ENERGY	
HEMATOLOGIC	☐	☐	ANEMIA	
	☐	☐	EASY BRUISING	
	☐	☐	BLOOD CLOTS IN DEEP VEINS OF ARMS/LEGS	
	☐	☐	BLOOD TRANSFUSSIONS	
	☐	☐	HIV / AIDS?	
VISION	☐	☐	BLINDNESS	
	☐	☐	DOUBLE VISION	
	☐	☐	DO YOU WEAR GLASSES OR CONTACT LENSES	
HEARING	☐	☐	DEAFNESS	
	☐	☐	RINGING IN EARS	
SKIN/INTEGUMENT	☐	☐	SKIN RASHES	
	☐	☐	UNUSUAL MOLES	
	☐	☐	BREAST LUMPS	
MUSCULAR/SKELETAL	☐	☐	BACK PAIN	
	☐	☐	HIP PAIN	
	☐	☐	KNEE PAIN	
	☐	☐	OTHER JOINT	SPECIFY WHICH JOINT:
	☐	☐	ARTHRITIS	
PSYCHIATRIC	☐	☐	DEPRESSION	
	☐	☐	ANXIETY	
	☐	☐	HALLUCINATION	
CONSTITUTIONAL	☐	☐	FEVER	
	☐	☐	CHILLS	
	☐	☐	SWEATS	
	☐	☐	WEIGHT LOSS OR GAIN	HOW MUCH?