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Colorectal, General & Weight Loss Surgery
Minimally Invasive Laparoscopic Surgery
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Medical Questionnaire

Patient's name: _____ **Age:** _____ **Main complaint:**_____
Primary physician/referring physician: _____ Phone:_____

Medical history:
Please list past and current medical illnesses: _____
_____
_____
Please list all surgeries you have had: _____
_____
_____
Hospitalization (reasons & dates):_____
_____
_____

Medications:
Current medications and dosages: _____
_____
_____
_____
_____

Allergy to medications:
Please list name of medications and types of reaction: _____
_____

Family medical history:
Please list affected member and the medical illnesses/cancer: _____
_____

Habits:
Do you currently smoke cigarette? _____ If no, have you ever smoked cigarette? _____
When did you quit? _____ How many do or did you smoke daily? _____
How many years have or did you smoked? _____
Do you drink alcoholic beverage? _____ How many drinks weekly and what type? _____
Have you ever used illicit or street drugs? _____ When was your last use? _____ What type? _____

Social history:
Marital status please circle one: single/married/divorced/widow(er)
How many children do you have? _____
What city/state do you live in?: _____ Occupation: _____

Do you have the following conditions:

Skin:
- Rash? □No □Yes
- Lump? □No □Yes
- Unusual change of a mole? □No □Yes

Head and neck areas:
- Visual problem besides needing glasses? □No □Yes
- Nose infection? □No □Yes
- Nose bleeding? □No □Yes
- Sore throat? □No □Yes
- Swelling/lump?
  - -in mouth or oral cavity? □No □Yes
  - -in neck area? □No □Yes

Cardiovascular/ heart-related:
- Short of breath:
  - -at rest? □No □Yes
  - -with activity? □No □Yes
  - -lying flat? □No □Yes
- Recent chest pain? □No □Yes
- Past heart attack? □No □Yes
- Congestive heart failure? □No □Yes
- Heart valve disease? □No □Yes
- Any leg or calf pain with walking? □No □Yes

Lung:
- Breathing problem? □No □Yes
- History of asthma? □No □Yes
- Any lung disease caused by smoking? □No □Yes
- Recurrent pneumonia? □No □Yes
- Recurrent bronchitis? □No □Yes
- Recent cough? □No □Yes
- Coughing blood? □No □Yes
- Sleep apnea? □No □Yes

Gastro-intestinal:
- History of liver disease? □No □Yes
- History of pancreatic disease? □No □Yes
- Swallowing problem? □No □Yes
- Heart burn? □No □Yes
- Nausea/vomiting? □No □Yes
- Blood in vomit? □No □Yes
- Recent change in appetite? □No □Yes
- Abdominal bloating? □No □Yes
- Abdominal pain? □No □Yes
- Diarrhea? □No □Yes
- Constipation? □No □Yes
- Recent change in bowel habit? □No □Yes
- Blood in stool? □No □Yes

Genitalia/Urinary:
- History kidney disease? □No □Yes
- History of kidney stone? □No □Yes
- Pain with urination? □No □Yes
- Blood in urine? □No □Yes
- Incomplete emptying of bladder? □No □Yes
- Frequent urination? □No □Yes
- Incontinence to urine? □No □Yes
- Female: abnormal vaginal discharge? □No □Yes
  - Taking birth control pills? □No □Yes
- Male: Testicle lump? □No □Yes

Hematological:
- Deep venous thrombosis (clot in veins)? □No □Yes
- Pulmonary embolus (clot in lungs)? □No □Yes
- Bleeding disorders? □No □Yes
- History of blood transfusion? □No □Yes

Endocrine:
- Diabetes? □No □Yes
- Thyroid diseases? □No □Yes
- High cholesterol or triglyceride? □No □Yes
- Pituitary tumor? □No □Yes
- Taking steroid? □No □Yes

Neurological:
- History of stroke? □No □Yes
- Nerve problem? □No □Yes

Musculo-skeletal:
- Degenerative or osteoarthritis? □No □Yes
- History of neck pain or problem? □No □Yes
- History of back pain or problem? □No □Yes
- Joint pain?
  - - shoulder □No □Yes
  - -hip □No □Yes
  - -knee □No □Yes
  - -ankle □No □Yes
- Muscle lump or swelling? □No □Yes

Infections:
- History of bacterial resistance infection? □No □Yes
- History of sexually transmitted disease? □No □Yes
- History of HIV/ AIDS? □No □Yes
- Histoy of hepatitis B or C infection? □No □Yes

General:
- Fever? □No □Yes
- Night sweat? □No □Yes
- Unexpected weight loss? □No □Yes
- Unusually fatigue? □No □Yes

Psychological:
- Depression? □No □Yes
- Alcohol abuse or drug addiction? □No □Yes
- Schizophrenia? □No □Yes

Please list any other symptoms not previuosly listed that you have significant concern with:

_____

_____