

MINIMALLY INVASIVE SURGERY INSTITUTE
225-769 -5028/fax 225-766-6996

OFFICE USE	
<input type="checkbox"/>	INS.
<input type="checkbox"/>	CP

MEDICAL QUESTIONNAIRE

Date: _____

Patient: _____

DOB: _____ Age: _____ Sex: _____

Patient's phone#: _____ Alternate #: _____

Email address (if available) _____

PROCEDURE

- Roux-en-Y Gastric bypass (laparoscopic or open)
- Laparoscopic adjustable gastric band
- Laparoscopic Sleeve Gastrectomy

OFFICE USE	
<input type="checkbox"/>	Y
<input type="checkbox"/>	M
<input type="checkbox"/>	N

PHYSICIAN

- Karl A. LeBlanc, M.D., MBA, FACS
- Mark G. Hausmann, M.D., FACS
- Kenneth P. Kleinpeter, Jr., M.D.

_____ Height

_____ Weight

_____ BMI (we will calculate this for you)

How did you hear about the doctor's of Minimally Invasive Surgery Institute, L.L.C.?

- Seminar
- Radio
- Print Ad
- Referral from Doctor
- Referred by existing patient
- Other:

Which Doctor? _____

What patient? _____

In the spaces provided below, please completely answer all questions to the best of your ability.

**HAVE YOU EVER HAD ANY UPPER-ABDOMINAL SURGERIES? YES/ NO
IF YES, EXPLAIN BELOW (TYPE OF SURGERY, DOCTOR, AND DATES):**

Please list all previous surgeries in the space provided below:

Major Illnesses:

How many pregnancies and list dates of each:

Miscarriages:

Please list all medications you are currently taking (please include dosages):

Are you currently taking any of the following medications?

Please check all boxes that apply to you.

Birth control pills Hormone replacements Aspirin Plavix

FAMILY HISTORY
(Grandparents, Parents, Siblings)

**What other family members are obese?
(indicate mother's/father's side of your family)**

What other family members have or have had Breast, Colon, or Prostate Cancer:

Cancer (specify type):

Diabetes:

Heart Attack:

Stroke:

High Blood Pressure:

Other problems not listed above:

SOCIAL INFORMATION

Marital Status: Single Married Divorced Widowed

Children: _____ **Number of People living in your home:** _____

Education: (please check all that apply)

Some school High School Graduate Some College College Graduate Post Graduate

Please briefly state the feelings of your spouse or partner in regards to bariatric surgery:

Please briefly state the feelings of your family in regards to bariatric surgery:

Smoking History: I do not smoke I quit smoking I smoke _____ pks/day

Alcohol Consumption: None Occasional/Socially Often (specify below amount per week)

Coffee / Caffeine Use: None Type: _____ Amount/day: _____

Carbonated beverages: None Type: _____ Amount/day: _____

Diet: None Type: _____

Frequent snacking: None Type: _____ Amount/day: _____

Physical Limitations (please check all that apply):

Climbing stairs Use of public seating Caring for personal needs

Playing with children Airline travel Work duties

Review of Systems

PLEASE READ THE FOLLOWING CAREFULLY AND CHECK ALL THAT APPLY

SYMPTOMS	YES	NO	COMMENTS
Freq/severe fatigue or weakness			
Fever/ chills/ sweats			
Frequent / severe headaches			
Any hx of head injury w/ loss of consciousness			
Eyeglasses or Contact lenses			
Visual problems that aren't correctable			
Hearing problems			
Chronic sinus congestion			
Dental problems			
Dentures			
Wheezing			
Coughing			
Breast lump, pain or discharge			
Heart murmur			
High blood pressure			
Birth control			
Infertility			
Anemia			
Any hx of blood transfusion			
Bleeding tendency			
Convulsions or Seizures			
Paralysis			
Numbness or Tingling			
Memory Loss			
Depression			
Anxiety			
Mood swings			
Sleep problems			
Drug or alcohol use			
Chronic skin rash or hives			
Asthma			

Review of Systems (cont'd)

SYMPTOMS	YES	NO	COMMENTS
Hay fever			
Morning Headaches			
Difficulty breathing while lying flat			
Must prop up on multiple pillows to sleep			
Excessive snoring			
Feeling like you aren't getting enough sleep			
Falling asleep during daytime activities/driving			
Waking up at night short of breath			
Stop breathing during sleep			
Frequent urination at night			
Delayed healing of sores or wounds			
Do you take blood pressure medications			
Chest pain at rest			
Chest pain on exertion			
Shortness of breath			
Discoloration of lower leg			
Swelling in feet			
Pain in joints			
Numbness/pain going down one or both legs			
Heartburn after eating			
Fluid coming up in throat when lying flat			
Food getting stuck when swallowing			
Skipping menstrual cycles			
Heavy or abnormal menstrual cycles			
Irregular periods			
Do you take medication for cholesterol			
Do you have thyroid problems			
Do you involuntarily lose your urine			
Any hx of bladder surgery			
Loose urine when sneezing/ coughing			
Loose urine when bending/ laughing			
Psychiatric treatment			
Hospitalization for psychiatric treatment			
Eating disorders			

DIET HISTORY

How long have you been overweight? _____

Where you overweight as a child? _____

After childbirth? _____

Please check all diet programs you have participated in and next to the program write in how long you participated in the program. (please also include dates)

YES	PROGRAMS	YES	PROGRAMS
	Diet medications		Virginia Mason Clinic
	Pritikin Diet		Mayo Clinic
	Slimfast		TOPS
	Low Calorie Diet		Rader Institute
	Subliminal Tapes		Hypnosis
	Physician Supervised Diet		Optifast
	High Protein		Airforce Diet
	Weight Watchers		Diet Center
	Herbal Life		Self Imposed Fasts
	Medifast		Cabrini Eating Disorder
	Living Well Lady		Magazine Diets
	Toopfast		Liquid Protein
	Jenny Craig		Nutri-System
	Overeaters Anonymous		HMR
	Numerous Book Diets		Over the counter preparations
	LA weight loss center		Any other not programs not listed

Please check any of the medications below that you have been prescribed and to the right please write in how long you were on the medications.

- Fen-Phen _____
- Redux _____
- Xenical _____
- Pondimin _____
- Tenuate _____
- Sanorex _____
- Ionamin _____

Please list any over-the-counter diet medications you have tried.

How did any of the above fail to meet your needs?

What is the most weight you have lost at one time?

At what age did you begin dieting?

Has your primary physician or any physician diagnosed you with any of the following diseases?

Check All That Apply

- Hypertension
- Diabetes
- Obstructive sleep apnea
- High Triglycerides
- High Cholesterol
- Arthritis
 - Knees
 - Ankles
 - Hips
- GERD (gastroesophageal reflux disease)
- Depression
- Degenerative joint disease
- Venous Stasis Disease
- Lumbar Disc Disease
- Polycystic Ovarian Syndrome
- Planter Fasciitis
- Urinary Stress Incontinence
- Insulin Resistance syndrome
- Syndrome X
- Amenorrhea
- Asthma
- Pseudotumor Cerebri
- Coronary Artery Disease
- Stroke
- Varicose Veins
- Chronic leg ulcers
- Chronic skin disorders or infections
- Breast cancer
- Uterine cancer
- Colon cancer
- Gestational Diabetes

Please list any and all physicians that are involved in your medical care:

(please list both first and last name, phone number, and address)

***Primary Care Physician:**

Physician's Name: _____

Physician's Address: _____

Physician's Telephone #: _____

***Other Attending Physicians:**