Name: ____ __/___/__ ___________

(Last) (First) (M.I.) Date of Birth

E-Mail Address:____

Operation Date:______________________ [ ] Gastric Bypass [ ] LapBand [ ] Realize Band [ ] Gallbladder [ ] Abdominoplasty [ ] Hernia Repair [ ] Sleeve

Any Complications after surgery?____

Reason for Office Visit: [ ] Routine *or* [ ] Other:_____________________________________

____

What exercise are you doing?____

List All Medications (Over the counter & herbal supplements)	List Any New Ilnesses or Hospitalizations (Include reason/date & surgeries)
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Are you experiencing problems with any of the below (please checkmark):

Cardiovascular	**Respiratory**	**Gastrointestinal**	**Neurological**	**Breast**	**General**
Heart Attack	Chronic Cough	Hepatitis	Stroke	Lump	Fever
High Blood Pressure	Chronic Bronchitis	Diverticulitis	Epilepsy	Discharge	Night Sweats
Irregular Heart Beat	Coughing up Blood	Chronic Diarrhea	Seizures	Cyst	Weight Loss
Ankle Swelling	Pulmonary Embolism	Constipation	Memory Loss	Cancer	Arthritis
Chest Pain w/ Exertion	Hoarseness	Blood in Stool	TIA	Infection	Back Pain
Shortness of Breath	Emphysema	Difficulty Swallowing	Paralysis		
Valvular Disease	Asthma	Jaundice	Disc Disease	**Endocrine**	**Blood**
Palpitation	Allergies	Gallstones	Depression	Diabetes	Bleeding Disorder
Heart Failure	Tuberculosis	Peptic Disease	Alzheimers	Adrenal	Phlebitis
Aneurysm	Lung Cancer	Hernia		Parathyroid	Anemia
Leg Cramps		Cancer		Thyroid	Blood Clot
Heart Murmur		Bowel Movement Changes		Pituitary	

Any Changes to your family health issues:____

Do you use any kind of tobacco? No / Rare / Occasional / Frequent

Are you having any pain? (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

Drink Alcohol? No / Rare / Occasional / Frequent Drug Abuse? Yes / No

Regarding your bariatric surgery (circle all that apply):

No Problems / **Nausea** / **Vomiting** / **Diarrhea** / **Constipation** / **Abdominal Pain** ? Please explain:

____

____

Any wound, skin, or hernia problems? ____

____

Any current dissatisfaction with your surgery? _________________________________

____

Todays weight:__________ Temp:_____________ BP:_________________ P:________________

[ ] Neuro intact and nonfocal { } NC/AT, EOMI, MMM [ ] Lungs CTA&P [ ] RRR, [} Abd: { } Wound benign and healing well { } Hernia No/Yes

[} LE edma (No/ Yes) [ ] Affect and behavior wnl [ ] neck supple ADDT EXAM:

[ ] Labs: WNL /Pnd / Notable:____

Imp: [ ] Appropriate progress [ ] Other:___________________________________

Tx: [ ] Reviewed ongoing nutritional supplements and discussed current diet with recommendations

[ ] Recommended RD f/u [ ] Psych f/u [ ] Labs ordered ASAP / Next Visir

Undersigned M.D. has reviewed the above information with patient.

Physician signature: ___________________________ Date: ____________________