Marc M. Zaré, MD
Advanced Laparoscopic
& Bariatric Surgery

Clinical Questionnaire

Please complete this form as accurately as possible:
Name: _____ Age: ___ Gender: ___
Referring Physician: _____
Other Physician currently treating you (& specialty):
_____
Reason for visit: _____
_____
Duration of illness: _____

PAST MEDICAL HISTORY (Current or past illnesses)

Heart
High Blood Pressure ☐ Yes ☐ No
High Cholesterol or lipids ☐ Yes ☐ No
Coronary Artery Disease ☐ Yes ☐ No
Heart Attack ☐ Yes ☐ No
Irregular Heart Beat ☐ Yes ☐ No
Other _____

Lung
COPD (Emphysema/Chronic Bronchitis) ☐ Yes ☐ No
Asthma ☐ Yes ☐ No
Pneumonia ☐ Yes ☐ No
Other _____

Gastrointestinal
Reflux Disease (or Hiatal Hernia) ☐ Yes ☐ No
Peptic Ulcer Disease ☐ Yes ☐ No
Gall Bladder Disease ☐ Yes ☐ No
Hepatitis B or C ☐ Yes ☐ No
Other _____

Endocrine
Diabetes Mellitus ☐ Yes ☐ No
Thyroid disease ☐ Yes ☐ No
Other _____

Cancer
Ever diagnosed with Cancer? ☐ Yes ☐ No
Year, type & treatment: _____

Blood Disorders
Anemia ☐ Yes ☐ No
Bleeding disorders/Excessive bleeding ☐ Yes ☐ No
Other _____

Musculoskeletal System
Osteoarthritis ☐ Yes ☐ No
Gout ☐ Yes ☐ No
Other _____

Peripheral Vascular Disease
Deep Vein Thrombosis (DVT) (Blood Clots) ☐ Yes ☐ No
Pulmonary Embolism (PE) ☐ Yes ☐ No
Varicose Veins ☐ Yes ☐ No
Arterial Vascular Disease ☐ Yes ☐ No
Other _____

Psychological Disorders
Depression ☐ Yes ☐ No
Anxiety ☐ Yes ☐ No
Other _____

Neurologic Disorders
Stroke ☐ Yes ☐ No
Alzheimer's ☐ Yes ☐ No
Other _____

Other illnesses not listed above: 1. _____
2. _____ 3. _____

PAST SURGICAL HISTORY
Please list all prior surgical procedures:: ☐ **None**
Type of Surgery _____ Year _____
Type of Surgery _____ Year _____
Type of Surgery _____ Year _____
Type of Surgery _____ Year _____
Have you had a complication after surgery? ☐Yes ☐ No
If yes, please explain: _____

ALLERGY TO MEDICATIONS ☐ **None**
Please list any medication to which you are allergic to:
1. _____ 2. _____
3. _____ 4. _____

CURRENT MEDICATIONS ☐ **None**
Please list all medications that you are currently using:

	Medications	Dose	Times/ day
1.			
2.			
3.			
4.			

FAMILY HISTORY
Has any family member had any of the following:
Difficulty with Anesthesia: ☐ Yes ☐ No
Excessive bleeding after a procedure: ☐ Yes ☐ No
If yes, please explain: _____ _____

SOCIAL HISTORY
Tobacco use: ☐ Current ☐ Past ☐ **None**
If yes, average use: ___ packets/day; duration: ___ years
Quit (if applicable) ___ years ago
Alcohol use: ☐ Current ☐ Past ☐ **None**
If yes, average use: ___ drinks/week; Type:_____
Quit (if applicable) ___ years ago
Occupation: _____ Employer _____

REVIEW OF SYSTEMS *Please **circle** any of the following symptoms you might have experienced over the past 3 months:*
Constitutional: Fever, Chills, Tiredness, Weight loss >10%
Psychologic: Anxiety, Depression, Difficulty Sleeping
Neurologic: Dizziness, Hand/Feet Tingling or Numbness
Eyes: Blurry vision, Eye pain
Ear/Nose/Throat: Ear ache, Nose Bleed, Change in Voice
Heart: Chest Pain, Shortness of Breath, Palpitation
Lungs: Cough, Sputum, Shortness of Breath, Wheezing
Gastrointestinal: Abdominal pain, Heartburn, Nausea, Vomiting, Bloating, Diarrhea, Constipation, Blood from Rectum
Genitourinary: Burning with Urination, Increased Frequency, Difficulty Controlling Bladder, Penile or Vaginal Discharge
Musculoskeletal: Pain in Joints, Muscles, or Bones
Skin: Skin Rash, Excessive Itching, Eczema, Dry skin
Hematologic: Excessive Bruising, Swollen Glands

Patient Signature: _____ Date: __/__/__
Surgeon's Comments: _____
_____
_____
Surgeon's Signature: _____ Date: __/__/__