

# INITIAL CONSULTATION

## Trace W. Curry, MD

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Reason for visit:  Gastric band  RNY Gastric Bypass  Sleeve Gastrectomy  Undecided  
 Medical Weight Loss (Fast Track, Adipex)  Other \_\_\_\_\_

REVIEW OF SYMPTOMS			
Do you now or have you ever had any problems related to the following systems? Please check all that apply			
<p><b>General/Skin</b></p> <input type="checkbox"/> No active problems <input type="checkbox"/> Fatigue <input type="checkbox"/> Fevers <input type="checkbox"/> Chills <input type="checkbox"/> Night sweats <input type="checkbox"/> Rash <input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss <input type="checkbox"/> Skin ulcers/cellulitis <input type="checkbox"/> Skin fold irritations <input type="checkbox"/> Skin fold infections	<p><b>Pulmonary</b></p> <input type="checkbox"/> No active problems <input type="checkbox"/> Choking at night <input type="checkbox"/> Frequent waking <input type="checkbox"/> Daytime drowsiness <input type="checkbox"/> Wheezing <input type="checkbox"/> Emphysema <input type="checkbox"/> Snoring <input type="checkbox"/> Short of breath <input type="checkbox"/> Persistent cough <input type="checkbox"/> Asthma <input type="checkbox"/> COPD	<p><b>Gastrointestinal</b></p> <input type="checkbox"/> No active problems <input type="checkbox"/> Heartburn/acid reflux <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Blood in stool <input type="checkbox"/> Irritable bowel <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting	<p><b>Genitourinary</b></p> <input type="checkbox"/> No active problems <input type="checkbox"/> Urinary incontinence <input type="checkbox"/> Blood in urine <input type="checkbox"/> Burning on urination <input type="checkbox"/> Prostate problems <p><b>Gynecological</b></p> <input type="checkbox"/> Vaginal infections <input type="checkbox"/> Irregular periods Last menstrual period _____ Are you pregnant _____ Current contraception _____
<p><b>Cardiac</b></p> <input type="checkbox"/> No active problems <input type="checkbox"/> Chest pain/angina <input type="checkbox"/> Heart attack/CAD <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Irregular heartbeat <input type="checkbox"/> Palpitations <input type="checkbox"/> Heart murmur	<p><b>Neurological</b></p> <input type="checkbox"/> No Active problems <input type="checkbox"/> Dizziness <input type="checkbox"/> Migraines/headaches <input type="checkbox"/> Numbness/tingling <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Vision Loss	<p><b>Musculo-Skeletal</b></p> <input type="checkbox"/> No active problems <input type="checkbox"/> Back/neck pain <input type="checkbox"/> Difficulty walking <input type="checkbox"/> Exercise limitations <input type="checkbox"/> Joint pain <input type="checkbox"/> Limited mobility---use cane, crutch, or wheelchair	<p><b>Psychiatric</b></p> <input type="checkbox"/> No active problems <input type="checkbox"/> Depression <input type="checkbox"/> Sexual abuse <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Anxiety/panic issues <input type="checkbox"/> ADD/OCD

### Medical History

Please check all that apply

- |  |  |   |   |   |
|--|--|---|---|---|
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Tuberculosis       | <input type="checkbox"/> Incontinence                       | <input type="checkbox"/> H-pylori       |
| <input type="checkbox"/> Bleeding disorder         | <input type="checkbox"/> COPD                    | <input type="checkbox"/> HIV/AIDS           | <input type="checkbox"/> Thyroid problems                   | <input type="checkbox"/> Gastritis      |
| <input type="checkbox"/> Blood clots in legs/lungs | <input type="checkbox"/> Emphysema               | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Heartburn/reflux                   | <input type="checkbox"/> Hiatal Hernia  |
| <input type="checkbox"/> Stroke/TIA/Seizure        | <input type="checkbox"/> Sleep apnea             | <input type="checkbox"/> Liver disease      | <input type="checkbox"/> Diabetes                           | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Congestive heart failure  | <input type="checkbox"/> Coronary artery Disease | <input type="checkbox"/> Kidney disease     | <input type="checkbox"/> Rheumatic fever                    | <input type="checkbox"/> Kidney stones  |
| <input type="checkbox"/> High blood pressure       | <input type="checkbox"/> Previous heart attack   | <input type="checkbox"/> High cholesterol   | <input type="checkbox"/> Gout                               | <input type="checkbox"/> Cancer _____   |
| <input type="checkbox"/> Irregular heart beat      | <input type="checkbox"/> Stent placed _____      | <input type="checkbox"/> High triglycerides | <input type="checkbox"/> Arthritis                          |   |
| <input type="checkbox"/> Stress test               | <input type="checkbox"/> Echo                    | <input type="checkbox"/> Diverticulitis     | <input type="checkbox"/> Polycystic Ovarian Syndrome (PCOS) |   |

### Past Surgical History

Please check all that apply

- |   |  |  |   |   |
|---|--|--|---|---|
| <input type="checkbox"/> Gallbladder    | <input type="checkbox"/> Hernia        | <input type="checkbox"/> Hemorrhoids               | <input type="checkbox"/> Heart surgery                | <input type="checkbox"/> Stomach surgery  |
| <input type="checkbox"/> C-sections     | <input type="checkbox"/> Breast        | <input type="checkbox"/> Colonoscopy               | <input type="checkbox"/> Angioplasty/Stents           | <input type="checkbox"/> Scope of stomach |
| <input type="checkbox"/> Hysterectomy   | <input type="checkbox"/> Appendix      | <input type="checkbox"/> Colon surgery             | <input type="checkbox"/> Previous weight loss surgery |   |
| <input type="checkbox"/> Tubal Ligation | <input type="checkbox"/> Thyroidectomy | <input type="checkbox"/> Knee surgery              | <input type="checkbox"/> Other surgery: _____         |   |
| <input type="checkbox"/> Pacemaker      | <input type="checkbox"/> Back surgery  | <input type="checkbox"/> Joint Replacement Surgery |   |   |
- Previous problems with anesthesia  No  Yes, Please describe \_\_\_\_\_

**MEDICATIONS:** Please list all daily medications including over the counter medications and vitamins, herbs or supplements

Name	Dosage	Frequency

**MEDICATION ALLERGIES:** Please list any known allergies or sensitivities and the reaction you had.

Name	Reaction

**OTHER ALLERGIES AND SENSITIVITIES:** Please list any known allergies or sensitivities and the reaction you had.

Name	Reaction
Latex            Yes        No	
IVP Dye        Yes        No	
Tape            Yes        No	
Iodine          Yes        No	

**Social History**

Please check all that apply

**Marital status:**  Single  Married/Partnered  Divorced  Separated  Widowed

**Religious preference:**  Catholic  Baptist  Methodist  Lutheran  Jehovah Witness  Atheists  Other \_\_\_\_\_

**Education:**  Grade school  High school  College  Graduate school  GED

**What type of work do you do?** \_\_\_\_\_

**Number of people living in your home** \_\_\_\_\_

**Smoking history:**  Never smoked  Smoke now  Used to smoke, stopped \_\_\_\_\_ packs/day for \_\_\_\_\_ years

**Chemical dependency:**  None  Using now  Used to use. Substance used \_\_\_\_\_

**Alcohol history:**  None  Beer  Wine  Liquor How often?  Daily  Weekly  Occasionally  Rarely

**Family History**

Please check all that apply

	Diabetes	High Blood Pressure	Heart attack	Stroke	Sleep Apnea
Mother					
Father					
Brother					
Sister					
Grandmother					
Grandfather					

Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Provider \_\_\_\_\_ Date \_\_\_\_\_