

Date: _____
Chart #: _____

Advanced Laparoscopic Associates, P.C.
Patient Questionnaire

First Name: _____ MI: _____ Last Name: _____

Nickname: _____ Email: _____

How did you hear about us?

Newspaper/Magazine

TV

Radio

Internet

Patient Referral:

Physician Referral:

Name and Address of Primary Care Physician: _____

Past Medical History:

1. Diabetes: Yes No
-If yes, which type: Type 1 Type 2
-When were you first diagnosed? _____

2. High Blood Pressure: Yes No

3. Heart Disease: Yes No
-If yes, check if you have had any of the following:
Chest Pain/Angina Heart Attack
Coronary Artery Disease Congestive Heart Failure
Cardiac Cath Atrial Fibrillation
Other: _____

4. Stroke: Yes No

5. High Cholesterol: Yes No

6. Arthritis: Yes No

7. Muscle and Joint Pain: **Yes** **No**
-If yes, check which of the following you have:
Joint pain Hip pain
Knee pain Foot/ankle pain
Leg/foot swelling Back pain
Gout Fibromyalgia
Other: _____

8. Sleep Problems: **Yes** **No**
-If yes, have you ever been diagnosed with sleep apnea? **Yes** **No**

9. Breathing Problems: **Yes** **No**
-If yes, check which of the following you have:
Asthma Chronic Bronchitis
Emphysema Pulmonary Hypertension
Shortness of Breath COPD
Other: _____

10. Gastrointestinal Problems: **Yes** **No**
-If yes, check which of the following you have:
Heartburn Difficulty swallowing
Barrett's Esophagus GERD(Gastro-Esophageal Reflux)
Other: _____

11. Autoimmune/Endocrine Disorders: **Yes** **No**
-If yes, check which of the following you have:
Hyperthyroidism Hypothyroidism
Systemic Lupus Addison's
Rheumatoid Arthritis Grave's Disease
Hashimoto's Multiple Sclerosis
HIV/AIDS
Other: _____

12. Blood Disorders: **Yes** **No**
-If yes, check which of the following you have:
Anemia Hemophilia
Blood clots Vitamin K Deficiency
Other: _____

5. Illicit Drug Use: **Yes** **No**

-If yes, which type of drug? _____

-If you use to abuse drugs, which type of drug was it and for how long did you abuse? _____

Medications: List any medications you are currently taking and the dose

Allergies: List any allergies to medications and the reaction you experience, or circle **NKDA** if you do not have any known drug allergies:

Surgical History:

| Type | Date | Location |
|-------------|-------------|-----------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

-Have you ever had any complications with anesthesia, such as malignant hyperthermia? **Yes** **No**

-Have any family members had any complications with anesthesia, such as malignant hyperthermia? **Yes** **No**

Review of Systems: Have you experienced any of these signs/symptoms within the past 12 months? Check Yes or No:

| | YES | NO |
|-----------------------|-----|----|
| Weight Loss | | |
| Weight Gain | | |
| Fevers/ Chills | | |
| Appetite Change | | |
| Fatigue | | |
| Weakness | | |
| Seizures | | |
| Numbness | | |
| Frequent Falls | | |
| Memory Loss | | |
| Fainting | | |
| Headaches | | |
| | | |
| Abdominal Pain | | |
| Nausea | | |
| Vomiting | | |
| Diarrhea | | |
| Constipation | | |
| Heartburn | | |
| Difficulty swallowing | | |
| Frequent urination | | |
| Joint Pain | | |
| Muscle Pain | | |
| Gout | | |
| Kidney problems | | |

| | YES | NO |
|------------------------|-----|----|
| Vision Changes | | |
| Hearing Changes | | |
| Thyroid problems | | |
| Palpitations | | |
| Chest pain | | |
| Heart Murmur | | |
| Shortness of Breath | | |
| Cough | | |
| Bronchitis | | |
| Pneumonia | | |
| Wheezing | | |
| | | |
| | | |
| Joint redness/swelling | | |
| Skin Rashes | | |
| Bed Sores | | |
| Blood Clots | | |
| Leg Swelling | | |
| Depression | | |
| Anxiety | | |
| Hallucinations | | |
| Suicidal thoughts | | |
| Suicidal attempts | | |
| | | |
| | | |