

**SOUTHERN CALIFORNIA ADVANCED LAPARO-ENDOSCOPIC SURGERY
LAPAROSCOPIC SURGERY EVALUATION**

Name: _____

Date: _____

Birthday: _____ / _____ / _____

Age: _____

I was referred to be evaluated by:

Physician: _____ MD
Address & Phone: _____

Provider: _____ P/ANP
Address & Phone _____

Friend: _____

It is my own idea to pursue surgery.

I am under the care of these other physicians as well:

Name:

Specialty:

Address & Phone

_____	_____	_____
_____	_____	_____
_____	_____	_____

I am here for my condition / problem (**circle one**):

Heartburn / GERD / Gastro-Esophageal Reflux Disease (Please See Sections **A & B**)

Para-esophageal Hernia / Hiatal Hernia (Please See Sections **A & C**)

Colon Cancer (Please See Sections **A & D**)

Diverticulitis / Diverticulosis (Please See Sections **A & E**)

Adrenal mass / tumor / lesion (Please See Sections **A & F**)

Spleen (Please See Sections **A & G**)

Hernia (groin, inguinal, umbilical, incisional, ventral) (Please See Sections **A & H**)

Gallstones / Gallbladder problem (Please See Sections **A & I**)

Other (Please See Sections **A & J**)

Everyone Must Fill Out All of Section **A** (In Entirety)

&

Your Appropriate Section

Do you have **Diabetes?**

Section A

- I do NOT have or have never had Diabetes

I HAVE:

- Type I or "Juvenile" or "Insulin Dependent" Diabetes
- Type II or "Adult Onset" or "Non-Insulin Dependent" Diabetes
- I had Diabetes while I was pregnant but not since

I was diagnosed in approximately (month) _____ / (year) _____ at age _____

I am currently under the care of a physician who specializes in treating Diabetes:

Doctor: _____

Specialty: _____

Address: _____

My doctor is currently treating my diabetes by:

- Observation and repeat testing
- I have been instructed to control my diet and see if that helps
- Weight loss by dieting or surgery has been recommended
- Pills (Please list Name and Dose):

Medicine	Dosage/milligrams	Times per Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- Insulin; Type and Dose:
I take _____ Units of _____ in the morning
I take _____ Units of _____ in the evening

- I take insulin based on my Sliding Scale Blood Sugar

I check my own blood sugar levels by testing my:

- Blood Finger Sticks
- Urine Dip Sticks

My Blood Sugar usually runs between _____ and _____

My doctor says that the control of my blood sugar is (circle one):

GOOD FAIR POOR UNCONTROLLED

I have been to an **Emergency Room** or admitted to the **Hospital** because of complications of Diabetes

Date: _____ Reason: _____

Date: _____ Reason: _____

I have physical limitations or impairments due to my Diabetes that include:

Additional comments concerning my Diabetes:

D
I
A
B
E
T
E
S

Do you have **Heart Disease** (Coronary Artery Disease, Angina ("Chest Pain"), Congestive Heart Failure, or other conditions)?

Section A

I do **NOT** have or have never had Heart Disease

My specific heart condition is called: _____

I was diagnosed in approximately (*month*) _____ / (*year*) _____ at age _____

I am currently under the care of a physician who specializes in Heart Disease:

Doctor: _____

Specialty: _____

Address: _____

I have been told by a medical doctor that my Heart Disease is due to:

- Genetic or Family Predisposition: _____
- Past Illness that affected my heart: _____
- Heart is poor due to another medical condition: _____
- No special reason that I am aware of; I just "have it": _____

Medical complications I have had or have that are due to the effects of Heart Disease include:

My doctor is currently treating my Heart Disease by

- Observation and repeat testing
- I have been instructed to control my diet and see if that helps
- Weight loss has been recommended
- I take the following medicines to control my heart disease:

Medicine	Dosage/milligrams	Times per Day
_____	_____	_____
_____	_____	_____
_____	_____	_____

I currently take:

- | | |
|--|---------------------------------------|
| <input type="radio"/> Aspirin | <input type="radio"/> Plavix |
| <input type="radio"/> NSAIDS (non-steroidals: Motrin, Advil) | <input type="radio"/> Coumadin |
| <input type="radio"/> Heparin (Lovenox, Fragmin) | <input type="radio"/> Vioxx, Celebrex |

I have been to an Emergency Room or admitted to the hospital because of complications of Heart Disease:

Date: _____ Reason: _____

Date: _____ Reason: _____

My doctor says that the control of my Heart Disease is (circle one):

GOOD FAIR POOR UNCONTROLLED

I have physical limitations due to my Heart Disease that include:

Walking / Stair Climbing: _____

Breathing: _____

Swelling: _____

Other: _____

Additional comments concerning my Heart Disease:

H
E
A
R
T

D
I
S
E
A
S
E

Do you have **Lung or Breathing Disease** (Pulmonary Hypertension, Sleep Apnea Syndrome [Sleep Apnea is when you stop breathing when asleep], Obesity Hypoventilation Syndrome, Asthma, Bronchitis)?

Section A

I do **NOT** have or have never had Lung or Breathing Diseases

My specific lung or breathing condition is called: _____
I was diagnosed in approximately (*month*) _____ / (*year*) _____ at age _____

- I have been told that I 'stop breathing' when I am asleep
- I have been recommended to undergo a Sleep Apnea Evaluation, but I haven't had it done
- I was diagnosed with Sleep Apnea in (*month*) _____ / (*year*) _____ at age _____
- I have been told to use a BiPAP or CPAP machine when I sleep
My BiPAP or CPAP machine settings are: _____
I use a BiPAP or CPAP machine (circle one): Every night, Most nights, Some nights, Never

I am, or have been under the care of a medical doctor who specialized in the treatment of Lung and Breathing Diseases:

Doctor: _____
Specialty: _____
Address: _____

I have been told by a medical doctor that my Lung or Breathing Disease is due to:

- Genetic or Family Predisposition
- Past Illness that affected my Lungs or ability to breathe well
- Lung/Breathing is poor Due to: _____
- Another medical condition: _____
- I was exposed to chemicals at my job
- Cigarette or Cigar Smoking:**
 - I still smoke ___ packs or cigars each day and have for _____ years
 - I no longer smoke, but averaged _____ packs or ___ cigars each day for ___ years
 - Other: _____

Medical complications I have had or have that are due to the effects of Lung or Breathing Disease include:

I have been to an Emergency Room or admitted to the hospital for complications of Lung or Breathing Disease

Date: _____ Reason: _____
Date: _____ Reason: _____

I have required Intravenous or Oral STEROIDS to control my asthma:

Describe Steroid treatments that you have required: _____

My doctor is currently treating my Lung or Breathing Disease by:

- Observation and repeat testing
- I have been instructed to control my diet and see if that helps
- I take the following medicines for my Lung or Breathing Disease:

Medicine	Dosage/milligrams	Times per Day
_____	_____	_____
_____	_____	_____

My doctor says that the control of my Lung or Breathing Disease is (circle one):

GOOD FAIR POOR UNCONTROLLED

Additional comments concerning my Lung or Breathing Disease:

L
U
N
G
S
-
B
R
E
A
T
H
I
N
G

Do you have **Liver Disease** (cirrhosis, hepatitis)?

Section A

I do **NOT** have or have never had Liver Disease

My specific condition is called: _____

I was diagnosed in approximately (*month*) _____ / (*year*) _____ at age _____

I am, or have been under the care of a medical doctor who specializes in the treatment of Liver Disease:

Doctor: _____

Specialty: _____

Address: _____

I have been told by a medical doctor that my Liver Disease is due to:

Genetic or Family Predisposition: _____

Due to another medical condition: _____

Obesity: _____

Other: _____

I have been to an Emergency Room or admitted to the hospital due to complications of Liver Disease:

Date: _____ Reason: _____

Date: _____ Reason: _____

I take the following medicines for Liver Disease:

Medicine	Dosage/milligrams	Times per Day
_____	_____	_____
_____	_____	_____
_____	_____	_____

Besides taking medicine, treatment for my Liver Disease includes:

Observation and repeat testing: _____

Weight loss has been recommended: _____

Other: _____

Additional comments concerning my Liver Disease:

L
I
V
E
R

D
I
S
E
A
S
E

Do you have any problems with **Bleeding, Blood Clots, Veins** or do you have any **Blood Disease** (Venous Stasis, Ulcers, Deep Vein Thrombosis, Pulmonary Embolus or "Blood Clots")?

I do **NOT** have or have never had Bleeding, blood Clots, Vein problems, or Blood Disease

Section A

My specific condition is called: _____

I was diagnosed in approximately _____ (month) / _____ (year) at age _____

I am, or have been under the care of a medical doctor who specializes in the treatment of Vein/Blood Disease:

Doctor: _____

Specialty: _____

Address: _____

I have been told by a medical doctor that my Vein/Blood Disease is due to:

Genetic or Family Predisposition: _____

Due to another medical condition: _____

Obesity: _____

Other: _____

I have been to an Emergency Room or admitted to the hospital due to complications of Vein/Blood Disease:

Date: _____ Reason: _____

Date: _____ Reason: _____

I have had blood clots form in my legs

After surgery: _____

For unknown reasons

I have had members of my immediate family have problems with Blood Clots

I have had problems bleeding too much

I have had problems bleeding after surgical or dental procedures

I have had blood transfusions
I was given approximately _____ units ("Pints") in my lifetime.
Please describe circumstances: _____

I received blood and now have a disease from it called: _____

I take the following medicines for Vein/Blood Disease:

Medicine	Dosage/milligrams	Times per Day
_____	_____	_____
_____	_____	_____
_____	_____	_____

I currently take:

Aspirin **Plavix**

Coumadin **NSAIDS (nonsteroidals: Motrin, Advil)**

Heparin (Lovenox, Fragmin) **Vioxx, Celebrex**

Additional comments concerning my Vein/Blood Disease:

B
L
O
O
D
&
V
E
S
S
E
L
S

Do you have a **Psychiatric Condition** (Depression, Social Isolation, Anxiety, Suicide, Drug Abuse, Alcoholism, or any other psychological condition)?

Section A

I do **NOT** have or have never had any Psychiatric Condition

My specific condition is called: _____

I was diagnosed in approximately _____ (month) / _____ (year) at age _____

I am, or have been under the care of a medical doctor who specializes in the treatment of Psychiatric Conditions

Doctor: _____

Specialty: _____

Address: _____

I have been in therapy: _____

I have been admitted to a hospital to undergo psychiatric care (describe): _____

I have had specialized psychiatric procedures (describe): _____

I have been told by a medical doctor that my Psychiatric Condition is due to:

Genetic or Family Predisposition: _____

Due to another medical condition: _____

Other: _____

I have been to an Emergency Room or admitted to the hospital due to complications of Psychiatric Conditions:

Date: _____ Reason: _____

Date: _____ Reason: _____

I take the following medicines for my Psychiatric Condition:

Medicine	Dosage/milligrams	Times per Day
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name of physician who is prescribing the above medications: _____

Specialty: _____

Additional comments concerning my Psychiatric Condition:

M
E
N
T
A
L

H
E
A
L
T
H

Do you have or have ever had **Cancer?**

Section A

I do **NOT** have or have never had Cancer

My specific Cancer is/was called: _____

I was diagnosed in approximately _____ (month) / _____ (year) at age _____

I am, or have been under the care of a medical doctor who specializes in the treatment of Cancer:

Doctor: _____

Specialty: _____

Address: _____

I have been told by a medical doctor that my Cancer is due to:

No obvious reason: _____

Genetic or Family Predisposition: _____

Environmental or Industrial exposure to a Cancer causing agent: _____

Due to another medical condition: _____

Other: _____

I have been to an Emergency Room or admitted to the hospital due to complications of Cancer:

Date: _____ Reason: _____

Date: _____ Reason: _____

I had my cancer removed surgically on (month) _____, (year) _____ at age _____.

The surgical procedure was called: _____

During the surgery the surgeon removed &/or operated on the following organs: _____

After surgery I had Radiation Therapy (describe): _____

After surgery, I had Chemo Therapy (describe): _____

I take the following medicines for the Cancer:

Medicine	Dosage/milligrams	Times per Day
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have been considered "Cancer Free" for _____ years.

I have had breast biopsies that turned out to be **non-cancerous**

I have had _____ biopsies of my **Left Breast** (year of biopsies: _____)

I have had _____ biopsies of my **Right Breast** (year of biopsies: _____)

Describe any evaluations you have had for suspected cancer that have turned out to show no cancer:

C
A
N
C
E
R

Do you have, or have you ever had **Kidney Disease?**

Section A

I do **NOT** have or have never had Kidney Disease

My specific condition is called: _____

I was diagnosed in approximately (*month*) _____ / (*year*) _____ at age _____

I am, or have been under the care of a medical doctor who specializes in the treatment of Kidney Diseases:

Doctor: _____

Specialty: _____

Address: _____

I have been told by a medical doctor that my Kidney Disease is due to:

Genetic or Family Predisposition: _____

High Blood Pressure: _____

Diabetes: _____

Obesity: _____

Due to another medical condition: _____

Other: _____

I have been to an Emergency Room or admitted to the hospital due to complications of Kidney Disease:

Date: _____ Reason: _____

Date: _____ Reason: _____

I take the following medicines for my Kidney Disease:

Medicine	Dosage/milligrams	Times per Day
_____	_____	_____
_____	_____	_____
_____	_____	_____

Besides taking medicine, treatment for my Kidney Disease includes:

Observation and repeat testing: _____

Weight loss has been recommended: _____

Dialysis has been recommended or performed: _____

Kidney transplant has been recommended or performed: _____

Other: _____

Additional comments concerning my Kidney Disease:

K
I
D
N
E
Y

D
I
S
E
A
S
E

Do you have any **Stomach, Intestinal, or Colon Diseases** (Gastrointestinal or 'GI Tract') diseases?

Section A

I do NOT have or have never had Stomach, Intestinal, or Colon Diseases

My specific condition is called: _____

I was diagnosed in approximately _____ (month) / _____ (year) at age _____

I am, or have been under the care of a medical doctor who specializes in the treatment of GI Tract Diseases:

Doctor: _____

Specialty: _____

Address: _____

I have had the following problems (describe):

- Stomach Ulcers: _____
- Stomach Bleeding: _____
- Polyps: _____
- Crohn's Disease: _____
- Ulcerative Colitis: _____
- Diverticulitis: _____
- Colon Bleeding: _____
- Appendicitis: _____
- Hemorrhoids: _____
- Constipation: _____
- Diarrhea: _____
- Inflammatory Bowel Disease: _____
- Irritable Bowel Syndrome: _____

I have had the following surgical procedures on my stomach, intestines, or colon:

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Date: _____ Surgery: _____

I have been to an Emergency Room or admitted to the hospital due to complications of the GI Tract:

Date: _____ Reason: _____

Date: _____ Reason: _____

I take the following medicines for diseases of my GI Tract:

Medicine	Dosage/milligrams	Times per Day
_____	_____	_____
_____	_____	_____
_____	_____	_____

Additional comments concerning my GI Disease: _____

I
N
T
E
S
T
I
N
E
S

Do you have or have ever had, a **Substance Abuse Problem** (Alcohol, Pills, Marijuana, IV Drugs, Cocaine, etc.)?

Section A

I do **NOT** have or have never had Substance Abuse Problems

I was addicted to: _____

I was addicted from (month) _____ to (year) _____

I stopped because: _____

I was able to stop:

On my own: _____

I was admitted to a Rehabilitation Center: _____

I was incarcerated: _____

I think I currently have a problem controlling my use of the following substances: _____

Additional comments concerning my Substance Abuse Problems: _____

S
U
B
S
T
A
N
C
E

A
B
U
S
E

Section A

I have had the following ***SURGICAL PROCEDURES*** during my lifetime:
 For EACH procedure PLEASE indicate: Which side; If performed with a laparoscope; If there was any difficulty or concern with placing the breathing tube for anesthesia; Bleeding; Infection; etc

<u>Procedure:</u>	<u>Year/Age:</u>	<u>Comments:</u>
Tonsils	_____	I had excessive bleeding: _____
Molar Tooth Extraction	_____	I had excessive bleeding: _____
Appendix	_____	This was done <input type="checkbox"/> With a Laparoscope <input type="checkbox"/> With an Open Incision The appendix was "burst" Complications? _____
Gall Bladder	_____	The surgery was scheduled electively The surgery was urgent My Pancreas was inflamed at the time This was done <input type="checkbox"/> With a Laparoscope <input type="checkbox"/> With an Open Incision A drain was placed after the surgery
Caesarian Section ("C-Section")	_____ _____ _____	The incision is <input type="checkbox"/> a side-to-side "bikini-line" type <input type="checkbox"/> in the middle "up and down" Complications? _____
Hysterectomy (Removal of Uterus)	_____	This was performed for Cancer: _____ Bleeding: _____ Fibroids: _____ Other: _____ The incision is: <input type="checkbox"/> a side-to-side "bikini-line" type <input type="checkbox"/> in the middle "up and down" Other procedures were performed at the time: _____
Ovary removal	Left _____ Right _____ Both _____	This was performed for Cancer: _____ Cysts: _____ Other: _____ This was done <input type="checkbox"/> With a Laparoscope <input type="checkbox"/> With an Open Incision <input type="checkbox"/> As part of another operation: _____

OTHER SURGICAL PROCEDURES:

<u>Procedure:</u>	<u>Year/Age</u>	<u>Comments:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have been involved in the following ***ACCIDENTS***:

<u>Accident:</u>	<u>Year/Age:</u>	<u>Injuries/Treatment:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Section A

I take the following *MEDICATIONS, DIETARY OR VITAMIN SUPPLEMENTS, AND HERBAL MEDICINES**.
(*Please list all prescription and non-prescription medications, as well as medications you take “only as needed” Even if listed prior.)

<u>Medication:</u>	<u>Dose (mg or #):</u>	<u>Times per day:</u>	<u>To Treat What?</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I currently take:

- Aspirin
- NSAIDS (nonsteroidals: Motrin, Advil)
- Heparin (Lovenox, Fragmin)
- Plavix
- Coumadin
- Vioxx, Celebrex

I am *ALLERGIC* to the following medicines:

<u>Medication:</u>	<u>Allergic Reaction:</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I Have No Known Drug Allergies

Which of the following cause you any *illness, difficulties, or concerns?*

Head / Brain: _____

Eyes / Vision: _____

Ears / Hearing: _____

Nose / Sinuses: _____

Mouth / Throat: _____

Neck: _____

Spine: _____

Lungs / Breathing: _____

Heart: _____

Stomach: _____

Intestines: _____

Liver: _____

Gall Bladder: _____

Spleen: _____

Pancreas: _____

Kidney: _____

Bladder: _____

Men:

Prostate: _____

Testes: _____

Women:

Ovaries: _____

Uterus: _____

Other: _____

Rectum / Anus: _____

Skin: _____

Breasts: _____

Arms: _____

Legs: _____

Arteries / Veins: _____

Bones: _____

Glands (Pituitary, Thyroid, Adrenal, etc): _____

Infectious Diseases (Hepatitis, HIV, Herpes, etc): _____

Personal Information

Employment: _____

Job Description: _____

Marital Status: _____

Children / Ages: _____

Tobacco use: Packs per Day _____ Years _____ Stopped _____

Alcohol use: _____

What are the support systems you have in place for your post-operative phase and long-term recovery?

What do you think we should know about you that we have not asked about?

END

GERD (GASTRO-ESOPHAGEAL REFLUX DISEASE) /
ANTI-REFLUX SURGERY EVALUATION

Section B

My symptoms started approximately on _____ (month/year), and can best be described as:

HEARTBURN

Describe the symptoms: _____

Certain foods or timing of meals make symptoms worse.

No () Yes: _____

Certain body positions or activities make symptoms worse.

No () Yes: _____

Symptoms awaken me at night.

No () Yes: () When this occurs, I: _____

I sleep on _____ pillows.

I sleep with the head of my bed elevated: No () Yes: _____

I have an acid or bile taste in my mouth in the morning.

No () Yes ()

Any additional symptoms or observations? _____

CHEST PAIN

My symptoms have been attributed to Heart problems ("heart attack").

No () Yes ()

I had a cardiac (heart) evaluation because of these symptoms.

No () Yes: EKG / Lab Tests / Stress Test / Angiogram Other: _____

ASTHMA

I have asthma.

No () Yes ()

I take the following medicines for my asthma:

Medicine	Dosage/milligrams	Times per Day
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have been told that my asthma has been caused or made worse because of heartburn.

No () Yes ()

PNEUMONIA

I have had repeated lung infections or pneumonias in the past.

No () Yes ()

I have had pneumonia _____ times.

I had pneumonia last _____ (month/year).

Section B

VOICE CHANGES

I have noticed progressive changes in my voice.

No () Yes ()

I have seen an ENT or Head and Neck physician for evaluation of my voice changes.

No () Yes ()

I have had an MD look at my vocal cords.

No () Yes ()

If yes, describe: _____

I have participated in the following medicines or treatments to control my Reflux:

<u>Medication / Treatment:</u>	<u>Year / Duration:</u>	<u>Success / Comments:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Lifestyle Changes	_____	_____
Antacids	_____	_____
Prilosec/Prevacid/Aciphex	_____	_____
Propulsid / Reglan	_____	_____

I have had the following studies performed to investigate my Reflux:

I have had specific tests to evaluate my Heartburn

- X-Rays (Barium Swallow, CT, MRI)
- A camera was put down my esophagus to look in my stomach (endoscopy)
- A biopsy revealed that I had a condition called "Barrett's Esophagus"
- I had a test to check the amount of acid in my esophagus (24-Hour pH Study)

<u>Procedure:</u>	<u>Year/Location:</u>	<u>Result:</u>
Upper GI X-Ray	_____	_____
Upper Endoscopy	_____	_____
Biopsies	_____	_____
Esophageal Manometry	_____	_____
24-Hour pH Study	_____	_____
CT Scan	_____	_____
Ultrasound	_____	_____
Other:	_____	_____
Other:	_____	_____

PARA-ESOPHAGEAL HERNIA / HIATAL HERNIA SURGERY EVALUATION

I have been experiencing (circle all that apply):

- Difficulty swallowing liquids
- Difficulty swallowing solids
- Pain when swallowing
- Regurgitation of food
- Weight Loss
- Weakness / Fatigue

- Chest Pain (see below)
- Abdominal Pain
- Heartburn (see below)
- Difficulty Breathing
- Other: _____

Please describe (frequency, severity, start of symptoms): _____

CHEST PAIN

My symptoms have been attributed to Heart problems ("heart attack").
No () Yes ()

I had a cardiac (heart) evaluation because of these symptoms.
No () Yes: EKG / Lab Tests / Stress Test / Angiogram Other: _____

HEARTBURN

Describe the symptoms: _____

Certain foods or timing of meals make symptoms worse.
No () Yes: _____

Certain body positions or activities make symptoms worse.
No () Yes: _____

Symptoms awaken me at night.
No () Yes: () When this occurs, I: _____

I sleep on _____ pillows.
I sleep with the head of my bed elevated: No () Yes: _____

I have an acid or bile taste in my mouth in the morning.
No () Yes ()

Any additional symptoms or observations? _____

I have participated in the following medicines or treatments to control my Reflux:

Section C

Medication / Treatment:	Year / Duration:	Success / Comments:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Lifestyle Changes	_____	_____
Antacids	_____	_____
Prilosec/Prevacid/Aciphex	_____	_____
Propulsid / Reglan	_____	_____

I have been told that I have a PARA-ESOPHAGEAL or HIATAL HERNIA: Yes or No

My lesion was diagnosed (discovered) on: _____ (month/year).

I have had the following studies performed to investigate my Hernia:

Procedure:	Year/Location:	Result:
Upper GI X-Ray	_____	_____
Upper Endoscopy	_____	_____
Biopsies	_____	_____
Esophageal Manometry	_____	_____
24-Hour pH Study	_____	_____
CT Scan	_____	_____
Ultrasound	_____	_____
Other:	_____	_____
Other:	_____	_____

I have had the previous abdominal surgeries

Procedure:	Year/Location:	Result:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

I am or have been under the care of a physician who specializes in the treatment of my Para-Esophageal / Hiatal Hernia:

Name:	Specialty:	Address & Phone:
_____	_____	_____
_____	_____	_____

DO NOT COMPLETE BELOW THIS LINE - FOR PHYSICIAN USE ONLY

END

Colon Mass/Lesion/Tumor Evaluation

Section D

I have been experiencing (circle all that apply): Abdominal Pain
Weight Loss
Blood in my stool
Weakness / Fatigue
Other: _____

Please describe (frequency, severity, start of symptoms): _____

I have been told that I have a lesion/mass/tumor in my colon: Yes or No

My lesion was diagnosed (discovered) on: _____ (month/year).

The lesion is said to be located in what part of the colon: _____

The lesion was diagnosed by:

- Colonoscopy
- Rectal exam
- CT Scan

I have had a tissue biopsy of the mass: Yes or No

If yes, the biopsy showed: _____

This was performed by _____ at _____

I have had the following studies performed to investigate my Colon:

<u>Procedure:</u>	<u>Year/Location:</u>	<u>Result:</u>
Colonoscopy	_____	_____
CT scan	_____	_____
Ultrasound	_____	_____
Other	_____	_____

CONTINUED ON NEXT PAGE

Section D

I have had the previous abdominal surgeries

<u>Procedure:</u>	<u>Year/Location:</u>	<u>Result:</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

I am or have been under the care of a physician who specializes in the treatment of my Colon:

Name: _____ Specialty: _____ Address & Phone: _____

DO NOT COMPLETE BELOW THIS LINE - FOR PHYSICIAN USE ONLY

END

DIVERTICULOSIS / DIVERTICULITIS EVALUATION

I have been experiencing (circle all that apply):

- Abdominal Pain
- Weight Loss
- Blood in my stool
- Weakness / Fatigue
- Fevers / Night Sweats
- Other: _____

Please describe (frequency, severity, start of symptoms): _____

I was diagnosed with diverticulitis in: _____ (Month/Year).

My diagnosis was made by:

- CT Scan
- Colonoscopy

Since then I have had _____ attacks in total.

<u>Year/Location:</u>	<u>Result:</u>
_____	_____
_____	_____
_____	_____

I have been hospitalized for my diverticulitis. Yes or No
 If Yes,

<u>Year/Location:</u>	<u>Result:</u>
_____	_____
_____	_____
_____	_____

I am currently on antibiotics for treatment of my diverticulitis: Yes or No

If yes, Antibiotic: _____ Started When: _____

Section E

I have had the following studies performed to investigate my Colon:

<u>Procedure:</u>	<u>Year/Location:</u>	<u>Result:</u>
Colonoscopy	_____	_____
CT scan	_____	_____
Ultrasound	_____	_____
Other	_____	_____

I have had the previous abdominal surgeries

	<u>Procedure:</u>	<u>Year/Location:</u>	<u>Result:</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

I am or have been under the care of a physician who specializes in the treatment of my Colon:

<u>Name:</u>	<u>Specialty:</u>	<u>Address & Phone:</u>
_____	_____	_____
_____	_____	_____

DO NOT COMPLETE BELOW THIS LINE - FOR PHYSICIAN USE ONLY

END

ADRENAL GLAND SURGERY EVALUATION

Section F

I have been experiencing (circle all that apply):

Abdominal Pain

Weight Loss

High Blood Pressure

Muscle Pains

Increased Frequency of Urination

Abnormal Hair Growth

Weight Gain

Heart Palpitations

Sweating

Diabetes

Weakness / Fatigue

Thinning skin

Discoloration of Abdominal Skin

Headaches

Other: _____

Please describe (frequency, severity, start of symptoms): _____

I have been told that I have a lesion/mass/tumor in my adrenal gland: Yes or No

The lesion is said to be located in the LEFT or RIGHT Adrenal Gland:

My lesion was diagnosed (discovered) on: _____ (month/year).

I have had the following studies performed to investigate my Adrenal Gland:

Procedure:

Year/Location:

Result:

MRI

CT scan

Ultrasound

I have had the following blood tests to diagnose my Adrenal Gland:

Blood Test

Year/Location:

Result

Section F

I have had the previous abdominal surgeries

	<u>Procedure:</u>	<u>Year/Location:</u>	<u>Result:</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

I am or have been under the care of a physician who specializes in the treatment of my Adrenal Gland:

Name: _____ Specialty: _____ Address & Phone: _____

DO NOT COMPLETE BELOW THIS LINE - FOR PHYSICIAN USE ONLY

END

Spleen Surgery Evaluation

I have been experiencing (circle all that apply):

- Abdominal Pain
- Weight Loss
- Fevers / Night Sweats
- Weakness / Fatigue
- Frequent Infections
- Abnormal Bleeding
- Low Blood Counts
- Other: _____

Please describe (frequency, severity, start of symptoms): _____

I have been told that I have a problem with my spleen: Yes or No

I have been told that my spleen is too big: Yes or No

I have a blood disorder: Yes or No

- If yes, my disorder is:
- ITP (Immune Thrombocytopenic Purpura)
 - Spherocytosis
 - Hemolytic Anemia
 - Other: _____

I was diagnosed with this blood disorder on: _____ (month/year).

I take the following medicines for my spleen/blood disorder:

Medicine	Dosage/milligrams	Times per Day
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have been on **steroids** in the past: Yes or No

If yes, when: _____ (month/year).

Steroid	Dosage/milligrams	Times per Day
_____	_____	_____

I am currently on **steroids**: Yes or No

Steroid	Dosage/milligrams	Times per Day
_____	_____	_____

Section G

My last platelet count was _____ on _____ (month/ year).

I have had the following studies performed to investigate my Spleen:

<u>Procedure:</u>	<u>Year/Location:</u>	<u>Result:</u>
MRI	_____	_____
CT scan	_____	_____
Ultrasound	_____	_____
Other	_____	_____

I have had the previous abdominal surgeries

	<u>Procedure:</u>	<u>Year/Location:</u>	<u>Result:</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

I am or have been under the care of a physician who specializes in the treatment of my Spleen or Blood Disorder:

Name: _____ Specialty: _____ Address & Phone: _____

DO NOT COMPLETE BELOW THIS LINE - FOR PHYSICIAN USE ONLY

END

Hernia Surgery Evaluation

Section H

I have been experiencing (circle all that apply):

- Abdominal Pain
- Nausea / Vomiting
- Intestinal Blockages
- Abdominal Cramps

Please describe (frequency, severity, start of symptoms): _____

My Hernia is located:

Groin Hernia

- Left Side Right Side

Diagnosed in, or present since ____ / ____ at age ____

Surgically repaired in ____ / ____ at age ____; Was mesh used? Yes No

Did hernia return after repair? No Yes: Repaired again in ____ / ____; Yes No

If repaired again was mesh used Yes No

Hernia in a surgical incision

Diagnosed in, or present since ____ / ____ at age ____

Surgically repaired in ____ / ____ at age ____; Was mesh used? Yes No

Did hernia return after repair? No Yes: Repaired again in ____ / ____; Yes No

If repaired again was mesh used Yes No

Hernia at my belly button

Diagnosed in, or present since ____ / ____ at age ____

Surgically repaired in ____ / ____ at age ____; Was mesh used? Yes No

Did hernia return after repair? No Yes: Repaired again in ____ / ____; Yes No

If repaired again was mesh used Yes No

Hernia between my breastbone and belly button

Diagnosed in, or present since ____ / ____ at age ____

Surgically repaired in ____ / ____ at age ____; Was mesh used? Yes No

Did hernia return after repair? No Yes: Repaired again in ____ / ____; Yes No

If repaired again was mesh used Yes No

CONTINUED ON NEXT PAGE

Section H

I have been to an Emergency Room or admitted to the hospital because of complications of my Hernia:

Date: _____ Reason: _____

Date: _____ Reason: _____

I have had the following studies performed to investigate my Hernia:

<u>Procedure:</u>	<u>Year/Location:</u>	<u>Result:</u>
MRI	_____	_____
CT scan	_____	_____
Ultrasound	_____	_____
Other	_____	_____

I have had the previous abdominal surgeries:

<u>Procedure:</u>	<u>Year/Location:</u>	<u>Result:</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

I am or have been under the care of a physician who specializes in the treatment of my Hernia:

Name: _____ Specialty: _____ Address & Phone: _____

DO NOT COMPLETE BELOW THIS LINE - FOR PHYSICIAN USE ONLY

END

Gallbladder / Gallstone Evaluation

I have been experiencing (circle all that apply):

Abdominal Pain

Fatty Food Intolerance

Pain Awakening Me at Night

Pain Radiating to My Back / Shoulder

Weight Loss

Nausea / Vomiting

Please describe (frequency, severity, start of symptoms):

Four horizontal lines for describing symptoms.

I have been hospitalized in the past for gallbladder attacks: Yes or No

If Yes,

Year/Location: _____

Result: _____

I have had pancreatitis in the past: Yes or No

If Yes,

Year/Location: _____

Result: _____

I have had jaundice (yellow skin) because of Gall Bladder Disease: Yes or No

If Yes,

Year/Location: _____

Result: _____

I have been told by a medical doctor that my Gall Bladder Disease is due to:

- Gall Stones
- "Spasm" of the Gall Bladder
- Genetic or Family Predisposition
- Due to another medical condition: _____
- Other: _____

My doctor is currently treating my Gall Bladder Disease by:

- Observation; I have stones but they cause no problems
- I have been instructed to control my diet and see if that helps
- Surgical removal of my Gall Bladder has been recommended
- Other: _____

Section I

I have had the following studies performed to investigate my Gallbladder:

<u>Procedure:</u>	<u>Year/Location:</u>	<u>Result:</u>
Ultrasound	_____	_____
CT Scan	_____	_____
MRI	_____	_____
ERCP / Endoscopy	_____	_____

I have had the previous abdominal surgeries

<u>Procedure:</u>	<u>Year/Location:</u>	<u>Result:</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

I am or have been under the care of a physician who specializes in the treatment of my Gallbladder / Gallstones:

<u>Name:</u>	<u>Specialty:</u>	<u>Address & Phone:</u>
_____	_____	_____
_____	_____	_____

DO NOT COMPLETE BELOW THIS LINE - FOR PHYSICIAN USE ONLY

END

Other Surgical Evaluation

Please describe the frequency, severity, and start of all symptoms):

Four horizontal lines for describing symptoms.

I have been hospitalized in the past for this condition: Yes or No

If Yes, Year/Location:

Result:

Two horizontal lines for Year/Location and two for Result.

I have had the following studies performed to investigate my this condition:

Procedure:

Year/Location:

Result:

Ultrasound

CT Scan

MRI

ERCP / Endoscopy

Colonoscopy

I have had the previous abdominal surgeries

Procedure:

Year/Location:

Result:

- 1. _____
2. _____
3. _____

CONTINUED ON NEXT PAGE

Section J

I am or have been under the care of a physician who specializes in the treatment of my
this condition:

Name:

Specialty:

Address & Phone:

DO NOT COMPLETE BELOW THIS LINE - FOR PHYSICIAN USE ONLY

END

TO BE COMPLETED BY SCALES STAFF ONLY

Additional Subjective

TEMPERATURE: _____ °F HEART RATE: _____ / MIN BLOOD PRESSURE: _____ / _____ RESPIRATIONS: _____ / MIN

Normal SKIN: _____

Normal LUNGS: _____

Normal CARDIAC: _____

Normal ABDOMEN: _____

Normal EXTREMITIES: _____

ADDITIONAL OBJECTIVE: _____

Lab Tests of ____ / ____ / ____

Normal Pending CBC: Normal Pending UGI: _____

Normal Pending Chem Panel: Normal Pending EGD: _____

Normal Pending Calcium: Normal Pending ERCP: _____

Normal Pending Albumin: Normal Pending MR: _____

Normal Pending Iron: Normal Pending Colonoscopy: _____

Normal Pending LFTs: Normal Pending CT: _____

Pathology Results _____

IMPRESSION / RECOMMENDATION

Studies / Labs for Next Appointment:

NEXT APPOINTMENT: ____ / ____ / ____ @ ____: ____

____ PA
(Reviewed with PA: _____ MD
____ / ____ / ____
____ MD