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PATIENT INFORMATION PACKET

Name _____ Date _____

E-mail _____ Phone (____) _____

PRIMARY CARE PHYSICIAN: _____

CARDIOLOGIST: _____ PULMONOLOGIST: _____

Please list any other doctors you regularly visit:

_____, Specialty: _____
_____, Specialty: _____
_____, Specialty: _____

PERSONAL & FAMILY HISTORY: If you and/or any blood relative have suffered any of the following, please mark and indicate relationship.

- Checkboxes for medical conditions: Anemia, Asthma, Bleeding, Blood clots, Cancer, Diabetes, Epilepsy, Gallstones, Glaucoma, Scleroderma, Gout, Heart Disease, High Cholesterol, Hypertension, Kidney Disease, Migraine, Obesity, Sleep apnea, Stroke, Lupus.

Other Auto Immune disorders: _____

SOCIAL HISTORY:

- Checkboxes for social history questions: Are/where you a smoker?, Have you quit smoking?, Consume alcohol, Use recreational drugs?, Yes/No, For how long?, Packs/day, How long ago?, Drinks/day, Type/frequency?

How is your health in general? [] Good [] Fair [] Poor

PLEASE LIST ANY MEDICATIONS TO WHICH YOU ARE ALLERGIC:

Medication	Reaction
_____	_____
_____	_____

LIST ANY MEDICATIONS, VITAMINS AND/OR SUPPLEMENTS YOU ARE PRESENTLY TAKING: (Continue on back)

Medication	Dosage	Time taken
_____	_____	_____
_____	_____	_____
_____	_____	_____

REVIEW OF SYSTEMS:

HEENT

- | | | |
|--|--|--|
| <input type="checkbox"/> Decreased hearing | <input type="checkbox"/> Eye Infections (frequent) | <input type="checkbox"/> Nose Bleeds (recurrent) |
| <input type="checkbox"/> Ringing in Ear | <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Ear Infections (frequent) | <input type="checkbox"/> Failing Vision | <input type="checkbox"/> Sore Throat (frequent) |
| <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> Double/Blurred Vision | <input type="checkbox"/> Hay Fever/Allergies |
| <input type="checkbox"/> Fainting Spells | | |

PULMONARY

- | | | |
|---|--|--|
| <input type="checkbox"/> Lung problems | <input type="checkbox"/> Asthma/Wheezing | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Pneumonia/Pleurisy | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Hyperventilation syndrome |
| <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Do you use CPAP? | |
| <input type="checkbox"/> Shortness of Breath | _____ on exertion _____ lying flat | |
| <input type="checkbox"/> Does your family say you have loud and/or irregular snoring? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

GASTROENTEROLOGY

- | | | |
|--|---|---|
| <input type="checkbox"/> Loss of appetite (recent) | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Abdominal pain (chronic) |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Hernia | <input type="checkbox"/> Change in bowel habits |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Bloody/Tarry Stools | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Crohn's/Colitis |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Jaundice/Hepatitis | |
| <input type="checkbox"/> Heartburn | Take antacids or medication? <input type="checkbox"/> Yes <input type="checkbox"/> No | For how many years? _____ |
| <input type="checkbox"/> GERD | Take medication for GERD <input type="checkbox"/> Yes <input type="checkbox"/> No | For how many years? _____ |
| <input type="checkbox"/> Had upper gastrointestinal (UGI) endoscopy? | <input type="checkbox"/> Yes <input type="checkbox"/> No | When? _____ |

GENITOURINARY

- | | | |
|--|--|--|
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Urinary Infections (frequent) | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Urethral discharge | <input type="checkbox"/> Urination overnight |
| <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Decrease in force/flow | <input type="checkbox"/> Urinary stress incontinence |
| <input type="checkbox"/> Infertility | Is there a diagnosis? _____ | |

Males: Prostate enlargement

Females: Date of last menstrual period: _____ Are your periods Regular Yes No

Are you using birth control? Yes No If yes, what type? _____

Number of pregnancies: _____ Number of live births: _____ Menopause

CARDIOVASCULAR

- High Blood Pressure (Hypertension) Yes No For how many years? _____
- Heart disease Describe: _____
- Heart Murmur Palpitations Irregular Pulse
- Varicose Veins/Phlebitis Swollen Ankles Leg Pain (when walking)

NEUROLOGY/PSYCHIATRY

- Seizures Muscle weakness Difficulty sleeping
- Stroke Numbness/Tingling Headache (frequent)
- Tremors/Hands shaking Nervousness Moodiness (in excess)
- Memory loss Mental illness Describe: _____
- Suicidal Depression Hospitalized for depression Yes No

HEMATOLOGY/ONCOLOGY

- Anemia (low hemoglobin) Abnormal bleeding or clotting Bruise easily
- Cancer or other tumor? Yes No Specify: _____
- HIV Positive? Yes No

ENDOCRINOLOGY/METABOLIC

- Elevated Cholesterol Chronic fatigue Phobias Thyroid Disease
- Do you have Diabetes? Yes No When were you diagnosed? _____

DERMATOLOGY

- Rashes Hives Psoriasis Eczema

MUSCULOSKELETAL

- Lower leg ulcers Fibromyalgia Arthritis Rheumatism
- Osteoporosis Bone Fracture Back Pain (recurrent) Foot Pain
- Gout Cold Numb Feet
- Do you have bone, joint or muscle problems? Yes No Diagnosis: _____
- Spine Hip Knee Ankle Other: _____

MISCELLANEOUS

- Measles Chicken Pox Rheumatic Fever Tuberculosis
- Mumps Herpes Scarlet Fever

SURGERY:

- Have you had surgery on your abdomen? Yes No
- Removal of gall bladder _____ Open or _____ Laparoscopic Date: _____
- Hysterectomy (removal of uterus) Date: _____ C-section (s) Date: _____
- Appendectomy Date: _____ Tubal ligation Date: _____

Please list any other procedures you might have had, including dates and Hospitals.

Name _____ Date _____
E-mail _____ Phone (_____) _____

WEIGHT LOSS HISTORY:

Please check the appropriate boxes and add notes as needed (be as specific as possible).

My obesity started: in childhood at puberty as an adult
 after pregnancy after a traumatic event _____

Additional notes regarding the onset of obesity: _____

Height: _____ Weight _____
Highest adult weight: _____ at age: _____
Lowest adult weight: _____ at age: _____
Most weight lost on any program: _____ Program and year: _____
How long did it take you to lose weight? _____
Did you gain any back? _____ After how long? _____
At what weight have you felt your best or do you think you would feel your best? _____

Why are you seeking bariatric surgery at this time? _____

Why do you think success is possible this time? _____

Surgery preference: Lap-Band Bypass Sleeve

What are the attitudes of the following people about your attempt(s) to lose weight?

	Spouse	Children	Parents	Friends	Co-workers
Positive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indifferent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Negative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do these attitudes affect your weight loss or gain? Yes No

If yes, please describe: _____

Have you ever:	Yes	No	When was the last time you did it?
Induced vomiting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Binge eaten (eat uncontrollably)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Taken laxatives	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you take vitamin, mineral or nutritional supplements? Yes No

TASTE PREFERENCES (please check all that apply)

Sweets Salty Fast Food Comfort food: _____

EATING HABITS (please check all that apply)

Stress Boredom Loneliness Other: _____

How fast do you normally eat? Quickly Fast Moderately

Do you chew your food thoroughly? Yes No Sometimes

Please list food allergies: _____

Do you have any food intolerances or special diet needs that you follow now? Yes No

If yes, please list: _____

Are there foods that you dislike and refuse to eat? _____

What are your favorite foods? _____

Circle equipment do you already have? Blender Food processor Fine sieve Measuring cups

Have you read about food and beverage guidelines you will need to follow after surgery? Yes No

Do you know how to make smooth, blenderized foods? Yes No

Do you understand how to read food labels? Yes No

Do you understand the consequences of not complying with the food guidelines after surgery? Yes No

Do you understand the long-term changes in food intake that will be necessary for all occasions after surgery for the rest of your life? Yes No

Do you know if you are eating or drinking for reasons other than hunger or thirst Yes No

Can you tell when you are physically satisfied with the amount of food you have eaten? Yes No

Can you tell when your stomach is "full"? Yes No

Can you tell when your stomach is "stuffed"? Yes No

Do you like to drink water? Yes No

WOMEN ONLY:

History of infertility: _____

Plans to become pregnant: _____

WEIGHT LOSS PROGRAMS, DIETS AND/OR MEDICATIONS: (please check all that apply)

Program	Dates (From - To)	Start Weight	End Weight
<input type="checkbox"/> Acupuncture	_____	_____	_____
<input type="checkbox"/> Alli	_____	_____	_____
<input type="checkbox"/> Atkins	_____	_____	_____
<input type="checkbox"/> Bontril	_____	_____	_____
<input type="checkbox"/> Diet Center	_____	_____	_____
<input type="checkbox"/> Grapefruit Diet	_____	_____	_____
<input type="checkbox"/> Herbal Life	_____	_____	_____
<input type="checkbox"/> Hoodia	_____	_____	_____
<input type="checkbox"/> Hydroxycut	_____	_____	_____
<input type="checkbox"/> Jenny Craig	_____	_____	_____
<input type="checkbox"/> Mayo Clinic	_____	_____	_____
<input type="checkbox"/> Mazanor	_____	_____	_____
<input type="checkbox"/> Medifast	_____	_____	_____
<input type="checkbox"/> Meridia	_____	_____	_____
<input type="checkbox"/> Metabolife	_____	_____	_____
<input type="checkbox"/> Nutrasystem	_____	_____	_____
<input type="checkbox"/> Optifast	_____	_____	_____
<input type="checkbox"/> Other – self implied diets	_____	_____	_____
<input type="checkbox"/> Phen-Phen	_____	_____	_____
<input type="checkbox"/> Quick program	_____	_____	_____
<input type="checkbox"/> Redux	_____	_____	_____

- Slimfast _____
- South Beach _____
- Trim Spa _____
- Weight Watchers _____
- Xenical _____

Medical weight management programs:

Additional Physician or Hospital supervised weight loss program:

PLEASE TRY TO RECALL YOUR LAST 24 HOUR INTAKE: (typical day)

BREAKFAST: _____

LUNCH: _____

DINNER: _____

SNACKS: (include all sweets & salty, any in between meal eating)

A.M. _____

P.M. _____

ANY BINGES OR OVERNIGHT EATING (if so why)? _____

HIGH CALORIE LIQUIDS INCLUDING SODA & ALCOHOL: _____

FRIED/FAST FOODS/PIZZA: _____

PLEASE GRADE HOW OBESITY HAS LIMITED EACH LIFE COMPONENT: (1=minimal, 5=severely affects)

	1	2	3	4	5
Physical activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self esteem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interest in sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Financial well being	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please tell us anything else that you would like us to know to help us provide you with the best possible care:

LIVE without the ~~weight~~ ^{wait}