DR. KURI & ASSOCIATES

THE #1 CHOICE FOR LAP-BAND® & GASTRIC SLEEVE SURGERY

Medical Questionnaire

Please complete and mail this questionnaire, along with your $500 deposit to:
DR. KURI & ASSOCIATES • PO Box 430697 • SAN DIEGO, CA 92143

SURGERY DATE_____

First Name_____

Last Name _____

Mailing Address_____

Phone (___) _____

Email _____

Primary Physician Name _____

Primary Physician Phone (___) _____

Emergency Contact Name _____

Emergency Contact Phone (___) _____

Relationship to Patient_____

DATE OF BIRTH: _____

AGE_____

GENDER _____

OCCUPATION_____

HEIGHT _____

WEIGHT_____

BMI_____

ALLERGIES_____

CURRENT MEDICATIONS: (please include birth control pills and over the counter medication or herbal medication/vitamins that you may take regularly)

Do you take Aspirin, Ibuprofen (Motrin), Naproxsen, or other NSAID? (YES) (NO)
Blood Thinner? (YES) (NO)

If YES, please list the medication type, dosage, and frequency:

Do you have High Blood Pressure (Hypertension)? (YES) (NO)

If YES, please list the medication type, dosage and frequency, as well as how long you have been on the medication:

Do you have Heart Problems or have you been diagnosed with a Heart Attack or Angina (chest pain)? (YES) (NO)

ARE YOU DIABETIC? (YES) (NO)

DO YOU SMOKE OR CHEW TOBACCO? (YES) (NO)

DO YOU HAVE ASTHMA? (YES) (NO)

If YES, do you use an inhaler? (YES) (NO)

DO YOU HAVE SLEEP APNEA? (YES) (NO)

DO YOU USE A C-PAP OR BI-PAP MACHINE WHILE SLEEPING? (YES) (NO)

DO YOU USE ALCHOHOL OTHER THAN SOCIALLY? (YES) (NO)

DO YOU USE RECREATIONAL DRUGS? (YES) (NO)

DO YOU HAVE A HISTORY OF HEPATITIS? (YES) (NO)

If you have Hepatitis, what type?

ARE YOU HIV POSITIVE? (YES) (NO)

DO YOU HAVE A HISTORY OF BLEEDING ULCERS? (YES) (NO)

DO YOU HAVE CROHN'S DISEASE? (YES) (NO)

HAVE YOU HAD PREVIOUS SURGERY? (YES) (NO)
If YES, what type and when?

HAVE YOU EVER HAD A REACTION TO ANESTHESIA? (YES) (NO)
If YES, please explain:

DO YOU HAVE ANY AUTO IMMUNE DISEASES? (YES) (NO)
If YES, please explain:

DO YOU HAVE ANY BLEEDING DISORDERS? (YES) (NO)

I, the patient, confirm that the information above is correct and complete.

Patient Signature: _____ Date: _____