FCB SURGICAL SPECIALISTS, P.C.
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REFLUX SURGERY PROGRAM QUESTIONNAIRE

Name: _____Date of Birth:_____ Race:_____

Address: _____

Phone Number: (Home)_____(Cell/Work)_____

Please provide your Primary Care Physician's information:

Physician's Name: _____

Physician's Address: _____

Phone Number: _____

Please provide your Gastroenterologist's information:

Physician's Name: _____

Physician's Address: _____

Phone Number: _____

Please circle the following if you are currently or have experienced any of these symptoms:

Please Rate Severity 1-3

1= monthly or less	**2= weekly**	**3= everyday**
Heartburn ___	Dysphagia ___	Reflux ___
Regurgitation ___	Odontophagia ___	Nausea ___
Vomiting ___	Abdominal Pain ___	Bloating ___
Belching ___	Bile in Mouth ___	Diarrhea ___
Loss of Appetite ___	Gas/Flatulence ___	Afraid to Eat ___
Get Full Quick ___	Difficulty Sleeping ___	

How long have you suffered from reflux? _____

What was your first symptom(s)? _____

What was your worst symptom(s)? _____

Do these symptoms occur while on medication? Yes___ No___

What medications have you taken in the past? Have they controlled your symptoms?

_____

_____

Are you currently or have you been under the care of another physician for this? Yes__ No__
If yes, please provide that information:

_____

_____

Have you had any diagnostic testing done for these conditions? Yes___ No___

Please indicate below if you had the testing and if so where it was done:

Upper Endoscopy _____

Manometry _____

Motility _____

24 Hour pH test _____

Gastric Emptying Study _____

Other than the symptoms described in the previous page, have you experienced any of these secondary symptoms? Please indicate below:

Please Rate Severity 1-3

1= monthly or less 2= weekly 3= everyday

Chest Pain/Angina ___	Sore Throat ___	Choking ___
Asthma ___	Difficulty Breathing ___	Wheezing ___
Coughing ___	Forced Vomiting ___	Hoarseness ___
Dental Erosion ___		

Do these problems effect your sleep? If yes, how so?

_____

_____

Are these symptoms associated with eating? Do specific foods trigger reflux?

_____

_____

How long after a meal do you experience these symptoms?

_____

What do you take to make it feel better?

_____

Have you tried prescription or over the counter medication? If so, please indicate which medication and what dosage.

_____

_____

MEDICAL HISTORY

Do you have or have you had any of the following in the past:

Heart Disease: Yes___ No___

- Chest Pain/Angina..... Yes___ No___
- Heart Attack.....How many events _____
- Coronary Artery Disease..... Yes___ No___
- Coronary Heart Failure.....Yes___ No___
- Arrhythmia.....Yes___ No___
- Atrial Fibrillation..... Yes___ No___
- Pacemaker.....Yes___ No___
- Pulmonary Embolism (blood clot in lung).....Yes___ No___
- High Blood Pressure.....Yes___ No___
- CVA (stroke).....Yes___ No___

Venous Insufficiency (varicose veins): Yes___ No___

Thrombophlebitis: Yes____ No____

Breathing Problems: Yes____ No____

- Asthma.....Yes___ No___
- Shortness of Breath.....Yes___ No___
- COPD.....Yes___ No____
- Emphysema.....Yes___ No___
- Other: _____

Sleep Problems: Yes___ No___

- Sleep Apnea Yes___ No___
- Snoring Yes___ No___
- Other: _____

Diabetes: Yes___ No___ If yes, how long: _____

- Diet Controlled.....Yes___ No___
- Medication Controlled.....Yes___ No___
- Insulin Dependent.....Yes___ No___
- Gestational Diabetes (pregnancy related).....Yes___ No___

Thyroid Issues: Yes___ No___

If yes, please specify:

_____

Arthritis: Yes___ No___

- Osteoarthritis.....Yes___ No___
- Rheumatoid Arthritis.....Yes___ No___

Gastrointestinal Issues: Yes___ No___

- Hiatal Hernia.....Yes___ No___
- Ulcers.....Yes___ No___
- Gallstones.....Yes___ No___
- Pancreatitis.....Yes___ No___
- Infected Gallbladder.....Yes___ No___
- Fatty Liver.....Yes___ No___
- Hepatitis.....Yes___ No___

Cancer: Yes___ No___

If yes, please specify:

_____

Are you currently receiving treatment or in remission? Yes___ No___

Current Medications (Please indicate dose and frequency of each medication):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies and Intolerances (Please indicate allergen and reaction):

_____ _____

_____ _____

SURGICAL HISTORY

Please check all that apply:

- C-Section____
- Tonsillectomy____
- Appendectomy____
- Gallbladder Surgery____
- Ventral Hernia Repair____
- Umbilical Hernia Repair____
- Carpal Tunnel Repair____
- Orthopedic Surgery Repair____
- Cosmetic Surgery____
- Other:_____
- Other: _____
- Other: _____

SOCIAL HISTORY

Marital Status: Single___ Married___ Divorced___ Widowed

Do you drink alcohol? Yes___ No___
If yes, how many drinks per day/week? _____

Do you smoke cigarettes? Yes___ No___
If yes, how many packs per day? _____ How many years have you smoked? _____
If you have quit, how long ago did you stop? _____
If you have quit, how many years did you smoke? _____

This Section to be Completed by Physician:

Review of Systems:

Head:
Neck:
Heart:
Lungs:
GU:
GI:
Ortho:
Skin:

Diagnostic Testing:

EGD
UGI
Manometry/Motility
24 pH
Gastric Emptying Study

Treatment Plan/Next Steps: