**Name _____** 
**Date _____**

**FOR ALL PATIENTS OF DR HERBST WITH AN ADIPOSE (FAT) TISSUE DISORDER**

**The goal of my visit today:**
□ To get or confirm a diagnosis □ Other: _____
□ To get recommendations for medical treatment _____
□ To get recommendations for surgery _____

**If you have pain, on a 0-10 scale with 0=no pain and 10=the worst pain ever please fill out the following**:
My average daily pain is: _____
Highest level of my pain is: _____ Lowest level of my pain is: _____

The pain I am describing is in my: □ Head □ Eyes □ Muscles □ Fat □ Arms □ Lipomas
(check all that apply) □ Ribs □ Stomach □ Back □ Legs □ Feet □ Joints

**Diet**
Average daily calories: _____
Number of meals per day: □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 or more
Number of snacks per day: □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 or more
Bread servings/slices per day: _____; type of bread - □ white □ wheat □ rye □ gluten-free □ tortilla
Servings of meat per day: _____; type of meat - □ fish □ chicken □ beef □ pork □ turkey
Servings of fruit per day: □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 or more
Servings of vegetables a day: □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 or more
Servings of fried food a day: □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 or more
Oil used for any food preparation: □ olive □ canola □ corn, sunflower □ flax □ _____

**Review of Systems**

| **General** | **Yes** | **No** | |
|---|---|---|---|
| Unexplained weight loss | | | If yes, amount: |
| Unexplained weight gain | | | If yes, amount: |
| Flu-like symptoms | | | |
| Difficulty sleeping | | | |

| **Head Eyes Ears Nose Throat** | **Yes** | **No** | |
|---|---|---|---|
| Thick skull fat | | | If yes, how long: |
| Difficulty Swallowing | | | If yes: □ solids □ liquids |
| Mouth sores | | | □ blurry □↓ acuity □ poor night vision |
| Neck feels swollen | | | |

| **Heart** | **Yes** | **No** | |
|---|---|---|---|
| Palpitations (pounding or irregular heart beat) | | | |
| Chest pain | | | □ at rest □ with activity |

**PLEASE COMPLETE THE OTHER SIDE →→→→→→**

| Dermatology | Yes | No | |
|---|---|---|---|
| Easy bruising | | | |
| Itching | | | □ skin □ fat |
| Water tricking under skin | | | |
| Burning sensations | | | □ skin □ fat □ feet □ fingers |
| Scabs or lesions on head | | | |
| Scabs or lesions elsewhere | | | |

| Endocrine | Yes | No | |
|---|---|---|---|
| Fatigue: rate | | | □1 □2 □3 □4 □5 □6 □7 □8 □9 □10 |
| Low body temperature | | | Typical temp: |
| High body temperature | | | Typical temp: |
| Feel thirsty all the time | | | |
| Tremors | | | □ hands □ feet |
| Hair loss | | | □ head □ underarms □ legs |

| Gastrointestinal | Yes | No | |
|---|---|---|---|
| Bloating | | | □ after meals □ always |
| Diarrhea | | | |
| Constipation | | | |
| Abdominal pain | | | □ inside □ in fat |
| Nausea | | | |
| Vomiting | | | |
| Early satiety (fill up easily when eating) | | | |

| Genitourinary | Yes | No | |
|---|---|---|---|
| Pain with intercourse | | | |
| Bladder pressure and pain | | | |
| Nocturia (get up at night to urinate) | | | How often: □1 □2 □3 □4 |

| Vascular | Yes | No | |
|---|---|---|---|
| Water retention (weigh more at night) | | | |
| Blood clot in vein | | | |
| Swelling (edema) | | | □ pitting □ non-pitting |
| Visible veins on legs | | | |
| Visible veins on arms | | | |

| Infectious Disease | Yes | No | |
|---|---|---|---|
| Cellulitis (infection of skin requiring antibiotics) | | | |
| Epstein barr virus titers high | | | Value: |
| Lyme's disease | | | |
| Inflammation in blood (high ESR or CRP) | | | Other: |

| Musculoskeletal/Rheumatology | Yes | No | |
|---|---|---|---|
| Muscle aches | | | □ arms □ thighs □ back |
| Joint aches | | | □ elbows □ wrist □ knees □ hips |
| Muscle weakness | | | □ arms □ legs □ trunk |
| Arms or legs jerk (myoclonus) | | | |
| Low back pain | | | |
| Dry eyes | | | |
| Dry mouth | | | |

**COMPLETE NEXT PAGE**
→→→→→→→→→→

| **Neurology** | **Yes** | **No** | |
|---|---|---|---|
| Vertigo (dizziness) | | | |
| Hearing loss | | | How long: |
| Headaches | | | □ migraine |
| Numbness | | | □ arms □ abdomen □ legs □ feet |
| Poor concentration/thinking | | | |
| | | | |
| **Pulmonary** | **Yes** | **No** | |
| Shortness of breath | | | How long: |
| Frequent congestion | | | |
| Sleep apnea | | | Use CPAP at night: □ Yes □ No |
| | | | |
| **Psychiatry** | **Yes** | **No** | |
| Depression | | | How long: |
| Anxiety | | | How long: |

Darken in areas of lipomas. Mark numb areas (∅∅∅)

Mark pain areas as follows: Stabbing pain (^^^); burning pain (~~~)