

Name _____

REVIEW OF SYMPTOM AND HISTORY FORM

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 _____

Exercise: What kind? _____

How often? _____ Do you sweat? Yes No

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			
Thick skull fat			If yes, how long:
Difficulty Swallowing			If yes: <input type="checkbox"/> solids <input type="checkbox"/> liquids
Mouth sores			<input type="checkbox"/> blurry <input type="checkbox"/> ↓ acuity <input type="checkbox"/> poor night vision
Neck feels swollen			
Heart			
Palpitations (pounding or irregular heart beat)			
Chest pain			<input type="checkbox"/> at rest <input type="checkbox"/> with activity

Dermatology	Yes	No	
Easy bruising			
Itching			<input type="checkbox"/> skin <input type="checkbox"/> fat
Water tricking under skin			
Burning sensations			<input type="checkbox"/> skin <input type="checkbox"/> fat <input type="checkbox"/> feet <input type="checkbox"/> fingers
Scabs or lesions on head			
Scabs or lesions elsewhere			
Endocrine			
Fatigue: rate			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10
Low body temperature			Typical temp:
High body temperature			Typical temp:
Feel thirsty all the time			
Tremors			<input type="checkbox"/> hands <input type="checkbox"/> feet
Hair loss			<input type="checkbox"/> head <input type="checkbox"/> underarms <input type="checkbox"/> legs
Gastrointestinal			
Bloating			<input type="checkbox"/> after meals <input type="checkbox"/> always
Diarrhea			
Constipation			
Abdominal pain			<input type="checkbox"/> inside <input type="checkbox"/> in fat
Nausea			
Vomiting			
Early satiety (fill up easily when eating)			
Genitourinary			
Pain in and around the genitals			
Bladder pressure and pain			
Nocturia (get up at night to urinate)			How often: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
Vascular			
Water retention (weigh more at night)			
Blood clot in vein			
Swelling (edema)			<input type="checkbox"/> pitting <input type="checkbox"/> non-pitting
Visible veins on legs			
Visible veins on arms			
Infectious/Allergic Disease			
Cellulitis (infection of skin requiring antibiotics)			
Seasonal allergies			Value:
Lyme's disease			
High ESR or CRP or CH50 lab tests?			Circle any positive.
Musculoskeletal/Rheumatology			
Muscle aches			<input type="checkbox"/> arms <input type="checkbox"/> thighs <input type="checkbox"/> back
Joint aches			<input type="checkbox"/> elbows <input type="checkbox"/> wrist <input type="checkbox"/> knees <input type="checkbox"/> hips
Muscle weakness			<input type="checkbox"/> arms <input type="checkbox"/> legs <input type="checkbox"/> trunk
Arms or legs jerk (myoclonus)			
Low back pain			
Dry eyes			

Dry mouth			
Neurology	Yes	No	
Vertigo (dizziness)			
Hearing loss			How long:
Headaches			<input type="checkbox"/> migraine
Numbness			<input type="checkbox"/> arms <input type="checkbox"/> abdomen <input type="checkbox"/> legs <input type="checkbox"/> feet
Poor concentration/thinking			
Pulmonary	Yes	No	
Shortness of breath			How long:
Frequent congestion			
Sleep apnea			Use CPAP at night: <input type="checkbox"/> Yes <input type="checkbox"/> 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 (~~~)

