

Name: _____ **DOB:** _____ **Date:** _____

Age: _____ Height: _____ Weight: _____ Months at current weight? _____

Lifetime maximum weight? _____ 5 year **minimum** weight? _____ 5 year **maximum** weight? _____

What bothers you about your abdomen? _____

Why are you considering surgery now? _____

Activity Level: _____

Planning any weight loss?: Yes/ No

What are you doing to accomplish your weight loss goals? _____

Abdominal History

Any previous abdominal surgeries (Date/Surgeon)?

Any other questions you would like addressed?

Number of children: _____

Ages of children: _____

Plan on having more children? Yes/ No

Method of current birth control? _____

Patient Signature: _____

Any Personal history of the following?

If yes, please list approximate age of onset.

Yes No

- Chronic rashes on belly
- Intermittent rashes on belly
- Abdominal hernias
- Pain in legs with walking or standing
- Blood clots in legs / DVT
- Family History of Blood Clots / DVT
- Pulmonary Embolus (PE)
- New onset lower extremity swelling
- Sleep Apnea
- Asthma
- Smoking
- Constipation or Diarrhea
- Irritable bowel syndrome

For Nurse Use Only HR: _____ BP: _____ O2: _____ BMI: _____

Each Risk Factor Represents 1 Point	
<input type="checkbox"/> Age 41-60 years	<input type="checkbox"/> Acute myocardial infarction
<input type="checkbox"/> Swollen legs (current)	<input type="checkbox"/> Congestive heart failure (<1 month)
<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Medical patient currently at bed rest
<input type="checkbox"/> Obesity (BMI >25)	<input type="checkbox"/> History of inflammatory bowel disease
<input type="checkbox"/> Minor surgery planned	<input type="checkbox"/> History of prior major surgery (<1 month)
<input type="checkbox"/> Sepsis (<1 month)	<input type="checkbox"/> Abnormal pulmonary function (COPD)
<input type="checkbox"/> Serious Lung disease including pneumonia (<1 month)	
<input type="checkbox"/> Oral contraceptives or hormone replacement therapy	
<input type="checkbox"/> Pregnancy or postpartum (<1 month)	
<input type="checkbox"/> History of unexplained stillborn infant, recurrent spontaneous abortion (≥ 3), premature birth with toxemia or growth-restricted infant	
<input type="checkbox"/> Other risk factors _____	Subtotal:

Each Risk Factor Represents 5 Points	
<input type="checkbox"/> Stroke (<1 month)	<input type="checkbox"/> Multiple trauma (<1 month)
<input type="checkbox"/> Elective major lower extremity arthroplasty	
<input type="checkbox"/> Hip, pelvis or leg fracture (<1 month)	Subtotal:
<input type="checkbox"/> Acute spinal cord injury (paralysis) (<1 month)	

Each Risk Factor Represents 2 Points	
<input type="checkbox"/> Age 61-74 years	<input type="checkbox"/> Central venous access
<input type="checkbox"/> Arthroscopic surgery	<input type="checkbox"/> Major surgery (>45 minutes)
<input type="checkbox"/> Malignancy (present or previous)	
<input type="checkbox"/> Laparoscopic surgery (>45 minutes)	Subtotal:
<input type="checkbox"/> Patient confined to bed (>72 hours)	
<input type="checkbox"/> Immobilizing plaster cast (<1 month)	

Each Risk Factor Represents 3 Points	
<input type="checkbox"/> Age 75 years or older	<input type="checkbox"/> Family History of thrombosis*
<input type="checkbox"/> History of DVT/PE	<input type="checkbox"/> Positive Prothrombin 20210A
<input type="checkbox"/> Positive Factor V Leiden	<input type="checkbox"/> Positive Lupus anticoagulant
<input type="checkbox"/> Elevated serum homocysteine	
<input type="checkbox"/> Heparin-induced thrombocytopenia (HIT)	
(Do not use heparin or any low molecular weight heparin)	
<input type="checkbox"/> Elevated anticardiolipin antibodies	
<input type="checkbox"/> Other congenital or acquired thrombophilia	Subtotal:
If yes: Type _____	
* most frequently missed risk factor	

TOTAL RISK FACTOR SCORE:

