Center for Thoracic Surgery at Baylor University Medical Center

3410 Worth Street
Suite 235
Dallas, Texas 75246

Name:____ Age:__________ Date of Birth:_________________

Home Phone:__________________________________ Cell Phone:________________________________

E-mail____

May we contact you via email regarding events and updates? (Circle one) YES NO

Primary Doctor:______________________________________ Phone:_________________________________

Referring Doctor:_____________________________________ Phone:_________________________________

Why were you referred to a surgeon?____ __________

What surgeries have you had in the past? What year were they done?

(1)____ (4)____

(2)____ (5)____

(3)____ (6)____

What are your medical problems (e.g., high blood pressure, diabetes, heart disease, etc.)?

(1)____ (5)____

(2)____ (6)____

(3)____ (7)____

(4)____ (8)____

Have you ever had a "stress test" (yes or no)? When was the last one performed?______________________________

Who is your cardiologist?_____________________________________ Phone:___________________________

Family History

Father: Alive (yes or no)? Age:____________ Medical Problems:____

Mother: Alive (yes or no)? Age:___________ Medical Problems:____

Siblings: How many?___________________ Medical Problems:____

Children: How many?___________________ Medical Problems:____

Is there any history of cancer in your family (yes or no)? What types and who? ________________________________

____

Social History

Do you smoke (yes or no)? How many packs per day?____

How many years have you or did you smoke?_____________ When did you quit?___________________________

Do you drink alcohol (yes or no)? How much?____

Do you drink more than two drinks daily (yes or no)?

What is your occupation?____

Medications (Include dose and frequency) Allergies (Include type of reaction)

(1)____ (5)____

(2)____ (6)____

(3)____ (7)____

(4)____ (8)____

Do you take insulin or steroids (yes or no)?

Patient Review of Systems

Please checkmark if you experience or have experienced any of the following during the last 30 days

GENERAL

____Chills

____Fatigue

____Fever

____Weight loss of 10 lbs or more

____Weight gain of 10 lbs or more

____Loss of Appetite

____Problems w/anesthesia

CARDIAC

____Chest Pain

____Walking w/shortness of breath

____Palpitations

____Ankle/foot swelling

____Cramping pain in leg muscles

____Lightheadedness

____Rapid or fluttering heartbeat

____Hypertension

____Stroke

____Blood Clot in legs

EARS NOSE THROAT

____Hearing Loss

____Sinus Congestion

____Nosebleeds

____Hoarseness

____Throat Pain/Soreness

____Problem Snoring

EYES

____Vision Changes

____Double Vision

ENDOCRINE

____Diabetes

____Thyroid Problems

____Taken Steroids (ie Prednisone)

____Previous Organ Transplant

GASTROINTESTINAL

____Difficulty Swallowing

____Painful Swallowing

____Abdominal Pain

____Constipation/Diarrhea

____Nausea/Vomiting

____Heartburn

____Blood in stool

____Pancreatitis

____Gallstones

____Diverticulitis

____Ulcers

____Jaundice

____Cirrhosis

____Hepatitis

GENITOURINARY

____Problems urinating

____Loss of bladder control

____Frequent urination

____Blood in urine

____Burning/painful urination

MUSCULOSKELETAL

____Joint aches

____Muscle aches

____Back Pain

____Neck Pain

HEMATOLOGIC/LYMPHATIC

____Easy Bruising

____Night Sweats

____Poor wound healing

____Bleeding disorder or previous bleeding problems

____Previous blood transfusion

____Anemia

____Taking a blood thinner (Coumadin/Warfarin/Plavix, etc)

____Aspirin/NSAIDS or Arthritis medication in last 7 days

____HIV positive

NEUROLOGICAL

____Headaches

____Seizures

RESPIRATORY

____Cough

____Wheezing

____Coughing up phlegm or blood

____Shortness of breath

____Asthma/Emphysema

____Pneumonia

____Blood clot to lung

SKIN

____Rash/sores

____Itching

CANCER HISTORY

____Chemotherapy

____Radiation

NONE OF THE ABOVE ☐
PLEASE √ BOX

Patient Signature ______________________________ Date ____________________

Reviewed by ______________________________MD Date ____________________

Entered to EMR by ______________________________ Date ____________________