Baylor Scott & White Surgical Institute

Appt Date: _____**NAME**: _____**DOB**: _____**AGE**: _____

REFERRING PHYSICIAN: _____**PHONE**: _____

PRIMARY CARE PHYSICIAN: _____**PHONE**: _____

PREFERRED PHARMACY: _____**PHONE**: _____

WHAT ARE WE SEEING YOU FOR TODAY? _____

ARE YOU TAKING INSULIN, STEROIDS, BLOOD THINNERS OR HORMONE REPLACEMENT OR WT LOSS MEDS? YES OR NO

MEDICAL PROBLEMS/DIAGNOSES:(i.e., diabetes, heart disease, high blood pressure)

<1>_____ <4>_____

<2>_____ <5>_____

<3>_____ <6>_____

SURGERIES: (please include year)

<1>_____ <4>_____

<2>_____ <5>_____

<3>_____ <6>_____

ANY **PERSONAL** HISTORY OF MAJOR ANESTHESIA OR BLEEDING PROBLEMS? **YES OR NO**

FAMILY HISTORY:

MOTHER: LIVING OR DECEASED AGE: _____MEDICAL PROBLEMS? _____

FATHER: LIVING OR DECEASED AGE: _____MEDICAL PROBLEMS? _____

NUMBER OF SIBLINGS: _____MEDICAL PROBLEMS? _____

NUMBER OF CHILDREN: _____MEDICAL PROBLEMS? _____

HISTORY OF CANCER IN YOUR FAMILY? **YES OR NO** IF YES, PLEASE LIST WHO AND WHAT TYPE: _____

ANY **FAMILY** HISTORY OF MAJOR ANESTHESIA OR BLEEDING PROBLEMS? **YES OR NO**

SOCIAL HISTORY:

HAVE YOU EVER SMOKED? YES OR NO IF YES, HOW MUCH? _____PER DAY; HOW MANY YEARS? _____

WHEN DID YOU QUIT? _____

DO YOU CURRENTLY SMOKE? YES OR NO

DO YOU VAPE? YES OR NO

DO YOU USE SMOKELESS TOBACCO? YES OR NO IF YES, SNUFF OR CHEW (CIRCLE ONE)

DO YOU DRINK ALCOHOL? YES OR NO IF YES, HOW MANY DRINKS PER WEEK? _____

MORE THAN 2 DRINKS DAILY? YES OR NO

DO YOU LIVE INDEPENDENTLY? YES OR NO WHAT IS YOUR OCCUPATION? _____

PT NAME: _____

VITAL SIGNS					
WEIGHT:	**HEIGHT:**	**BP**	**/**	**PULSE:**	**TEMP:**

HAVE YOU RECENTLY HAD BLOODWORK, EKG OR CHEST XRAY? **YES OR NO** IF YES, WHEN? _____

LAST COLONOSCOPY? _____ **LAST PHYSICAL EXAM**: _____

HAVE YOU BEEN EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS? (PLEASE CIRCLE)

WEIGHT LOSS	YES OR NO	HOARSENESS OR CHANGE IN VOICE	YES OR NO
WEIGHT GAIN	YES OR NO	SHORTNESS OF BREATH AT REST/SLEEP	YES OR NO
FEVER, CHILLS, OR NIGHT SWEATS	YES OR NO	SLEEP APNEA	YES OR NO
APPETITE CHANGES	YES OR NO	PERSISTANT COUGH	YES OR NO
NAUSEA/VOMITING	YES OR NO	CHEST PAIN, AT REST/UPON EXERTION	YES OR NO
DIARRHEA	YES OR NO	IRREGULAR HEARTBEATS	YES OR NO
CONSTIPATION	YES OR NO	LEG SWELLING	YES OR NO
CHANGE IN BOWEL HABITS	YES OR NO	DIFFICULTY URINATING	YES OR NO
BLOOD IN STOOL	YES OR NO	BRUISING EASILY	YES OR NO
HEARTBURN OR REFLUX ISSUES	YES OR NO	ANXIETY	YES OR NO
DIFFICULTY SWALLOWING	YES OR NO	DEPRESSION	YES OR NO

HAVE YOU EVER HAD THE FOLLOWING?

PNEUMONIA- **YES OR NO** IF YES, WHEN? _____

HEART ATTACK- **YES OR NO** IF YES, IN THE LAST 6 MONTHS? _____

STRESS TEST- **YES OR NO** IF YES, WHEN? _____WHERE? _____

HEART CATH- **YES OR NO** IF YES, WHEN? _____WHERE? _____

STROKE? – **YES OR NO** IF YES, WHEN? _____ ANY DEFICIT OR PERSISTENT WEAKNESS? _____

HEART ANGIOPLASTY, STENTS, OR HEART SURGERY- **YES OR NO** IF YES, WHEN? _____

HOSPITALIZATION FOR CONGESTIVE HEART FAILURE- **YES OR NO** IF YES, WHEN? _____

BLOOD CLOT IN LEGS OR LUNGS? **YES OR NO**

DIFFICULTY WITH ANESTHESIA? **YES OR NO** IF YES, WHAT WAS THE REACTION? _____

ARE YOU CURRENTLY ON DIALYSIS? **YES OR NO** IF YES, WHAT TYPE? _____WHAT DAYS? _____

HAVE YOU HAD ANY OF THE FOLLOWING IN THE LAST 30 DAYS? (PLEASE CIRCLE)

CHEMOTHERAPY RADIATION ANY SURGICAL PROCEDURES OPEN WOUNDS

***WOMEN ONLY:** DO YOU PERFORM SELF BREAST EXAMS? **YES OR NO**; DO YOU HAVE NIPPLE DISCHARGE? **YES OR NO**

LAST MENSTRUAL PERIOD: _____ LAST MAMMOGRAM: _____

MEDICATION ALLERGIES

ARE YOU ALLERGIC TO ANY MEDICATIONS? **YES OR NO** IF YES, PLEASE LIST **BELOW**:

MEDICATION NAME: _____ REACTION: _____

MEDICATION NAME: _____ REACTION: _____

MEDICATION NAME: _____ REACTION: _____

MEDICATION NAME: _____ REACTION: _____

MEDICATIONS YOU ARE CURRENTLY TAKING:

MEDICATION NAME: _____ DOSE: _____

MEDICATION NAME: _____ DOSE: _____

MEDICATION NAME: _____ DOSE: _____

MEDICATION NAME: _____ DOSE: _____

MEDICATION NAME: _____ DOSE: _____

MEDICATION NAME: _____ DOSE: _____

MEDICATION NAME: _____ DOSE: _____

MEDICATION NAME: _____ DOSE: _____

MEDICATION NAME: _____ DOSE: _____

MEDICATION NAME: _____ DOSE: _____