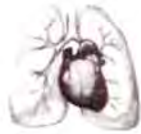


SOUTHWEST
Cardiothoracic Surgeons

THORACIC SURGERY
NEW PATIENT HEALTH HISTORY

GRAY SHADED AREAS ARE FOR OFFICE USE

Date of Visit: ______________________ Account Number: __________

Last Name: ____________________ First Name: ____________ MI: _____

Date of Birth: ____________________ Age: ___ Sex: M/F SS#: ________________

Primary Care Physician: ____________________ Requesting Physician: ______________

Reason for Office Visit Today: ____

HISTORY OF PRESENT ILLNESS **FOR OFFICE USE ONLY**

____

____

____

____

____

____

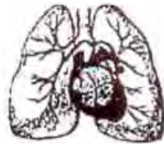
____

____

____

PAST MEDICAL HISTORY: (i.e. diabetes, high blood pressure…)

Diagnosis	Year Diagnosed
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	



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Do you have any of the following already prepared?

- [ ] Yes [ ] No Advanced Directives (Living Will)
- [ ] Yes [ ] No Durable Power of Attorney for Health Care
- [ ] Yes [ ] No Organ Donation
- [ ] Yes [ ] No Mental Health Directives

PAST SURGICAL HISTORY:

Please list any previous surgeries/procedures and approximate year below.

Surgical Procedure	Year
1 ______________________	________
2 ______________________	________
3 ______________________	________
4 ______________________	________
5 ______________________	________
6 ______________________	________
7 ______________________	________
8 ______________________	________
9 ______________________	________

Have you ever been hospitalized for any reason besides surgery: [ ] Yes [ ] No
If yes, reason and date: ______________________

Do you have any physical limitations? [ ] Yes [ ] No
If yes, please explain: ______________________

Have you ever had a blood transfusion: [ ] Yes [ ] No
If yes, when? ______________________ Adverse reaction? [ ] Yes [ ] No

Do you consent to the use of blood or blood products if necessary? [ ] Yes [ ] No
If no, please list religious or person reason______________________

My Medicine List

SpeakUP™

LIST ALL OF YOUR:

- Prescription Medicines
- Vitamins
- Diet Supplements
- Recreational Drugs
- Over the Counters (Example: Aspirin)
- Herbs
- Natural Remedies
- Amount of Alcohol you drink per day or week

It's important to include all of this information in case of an emergency.

List the amount that you usually take and how often or what time of day you take it.

Please feel free to take a medication card - keep it with you and keep it current.

Share it with your pharmacist, doctor and other caregivers.

WE ENCOURAGE YOU TO SPEAK UP™:

Speak up if you have questions or concerns, and if you still don't understand, ask again. It's your body and you have a right to know.

Pay attention to the care you get. Always make sure you're getting the right treatments and medicines by the right health care professionals. Don't assume anything.

Educate yourself about your illness. Learn about the medical tests you get, and your treatment plan.

Ask a trusted family member or friend to be your advocate (advisor or supporter).

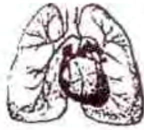
Know what medicines you take and why you take them. Medicine errors are the most common health care mistakes.

Use a hospital, clinic, surgery center, or other type of health care organization that has been carefully checked out. For example, The Joint Commission visits hospitals to see if they are meeting The Joint Commission's quality standards.

Participate in all decisions about your treatment. You are the center of the health care team.

The goal of the Speak Up™ program is to help patients become more informed and involved in their health care.

The Joint Commission



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ALLERGIES:

Please list all medications to which you have an allergy or an adverse response and the corresponding reaction

Medication	Reaction	Medication	Reaction

CURRENT MEDICATIONS:

Please list all medications (prescription and non-prescriptions), including vitamins, aspirin, herbs and /or appetite suppressants.

Name	Dose	Frequency

SOCIAL HISTORY

Martial Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

Number of children: ______________________________

Current hometown: ______________________________

With whom do you live? ______________________________

Who is at home to take care of you following surgery, or will you be residing elsewhere?
Please explain: ______________________________

Current (or previous) occupation: ______________________________
Are you retired? ☐ Yes ☐ No

How stressful is your job? ☐ None ☐ Mildly ☐ Moderately ☐ Very

List any hobbies: ______________________________

Do you exercise? ☐ Yes ☐ No
If yes, describe how and how often: ______________________________

Do you smoke? ☐ Yes ☐ No, but use to ☐ Never smoked
How many packs of cigarettes do/did you smoke per day? ______________________________
How many years have you smoked? ______________________________
When did you quit? ______________________________

Do you drink alcohol? ☐ Yes ☐ No, but use to ☐ Never drank
How much of the following did/do you drink in an average week?
________ glasses of wine ______ beers ______ drinks
When did you quit? ______________________________

Do you consume caffeine? ☐ Yes ☐ No, but used to ☐ Never
When did you quit? ______________________________
How much in an average day do you consume of the following:
______ Sodas ______ Cups of Coffee ________ Glasses of Tea

Do you take illicit drugs or abuse prescription medications?
☐ Yes ☐ No, but used to ☐ Never
If yes, please specify: ______________________________

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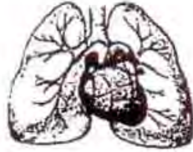

SOUTHWEST
Cardiothoracic Surgeons

FAMILY HISTORY

Please place a "X" in any box that applies to you.

ILLNESS	Father	Mother	Brother	Sister	Grand Father	Grand Mother	Son(s)	Daughter(s)
LIVING	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Age								
High Blood								
Pressure								
High Cholesterol								
Diabetes								
Heart Attack								
Other Heart Disease								
Lung Cancer								
Esophageal Cancer								
Esophageal Disease								
Breast Cancer								
Other Cancer (please specify)								
Blood or clotting disorder								
Stroke								
Sudden Death								

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REVIEW OF SYSTEMS

Please check all that apply and indicate the date the condition started.

I. General System Review

Yes	No	Condition	Date
☐ Yes	☐ No	Unintentional weight loss	______
☐ Yes	☐ No	Fever	______
☐ Yes	☐ No	Chills	______
☐ Yes	☐ No	Sweats	______
☐ Yes	☐ No	Fatigue	______

II. Lung System Review

Yes	No	Condition	Date
☐ Yes	☐ No	Chronic cough	______
☐ Yes	☐ No	New cough	______
☐ Yes	☐ No	Sputum production	______
☐ Yes	☐ No	Hemoptysis (coughing blood)	______
☐ Yes	☐ No	Hoarseness	______
☐ Yes	☐ No	Asthma	______
☐ Yes	☐ No	Wheezing	______
☐ Yes	☐ No	Shortness of breath at rest	______
☐ Yes	☐ No	Shortness of breath with activity	______
☐ Yes	☐ No	Bronchitis	______
☐ Yes	☐ No	Pneumonia	______
☐ Yes	☐ No	Sleep Apnea	______
☐ Yes	☐ No	Snoring	______
☐ Yes	☐ No	Tuberculosis	______

III. Previous Pulmonary Testing

Yes	No	Test	Date/Location
☐ Yes	☐ No	Chest x-ray	Date/Location ______
☐ Yes	☐ No	CT scan	Date/Location ______
☐ Yes	☐ No	PET scan	Date/Location ______
☐ Yes	☐ No	Needle Biopsy	Date/Location ______
☐ Yes	☐ No	Pulmonary function tests	Date/Location ______
☐ Yes	☐ No	Bronchoscopy	Date/Location ______
☐ Yes	☐ No	Tissue biopsy	Date/Location ______

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IV. *Cardiovascular System Review*

Yes	No	Condition	Date
☐ Yes	☐ No	Diabetes (insulin Dependent: Yes No	________
☐ Yes	☐ No	High blood pressure	________
☐ Yes	☐ No	High cholesterol	________
☐ Yes	☐ No	History of weight loss medicine (i.e. phen/fen)	________
☐ Yes	☐ No	Rheumatic/scarlet fever	________
☐ Yes	☐ No	Heart murmur	________
☐ Yes	☐ No	Chest Pain	________
☐ Yes	☐ No	Shortness of breath	________
☐ Yes	☐ No	Coronary artery disease	________
☐ Yes	☐ No	Heart attack	________
☐ Yes	☐ No	Abnormal EKG	________
☐ Yes	☐ No	Arrhythmia (abnormal heart rhythm)	________
☐ Yes	☐ No	Hospitalized for cardiac reasons	________
☐ Yes	☐ No	Any other type of heart disease	________

V. *Previous Cardiovascular Testing*

Yes	No	Test	Date	Location
☐ Yes	☐ No	Stress Test	Date ________	Location ________
☐ Yes	☐ No	Echocardiogram	Date ________	Location ________
☐ Yes	☐ No	Nuclear study	Date ________	Location ________
☐ Yes	☐ No	Holter	Date ________	Location ________
☐ Yes	☐ No	Carotid ultrasound	Date ________	Location ________
☐ Yes	☐ No	Catheterization/Angiogram	Date ________	Location ________
☐ Yes	☐ No	Electrophysiology study	Date ________	Location ________
☐ Yes	☐ No	CT Angiogram	Date ________	Location ________

VI. *Vascular System Review*

Yes	No	Condition	
☐ Yes	☐ No	Carotid artery disease	________
☐ Yes	☐ No	Renal artery disease	________
☐ Yes	☐ No	Peripheral artery disease (poor leg circulation)	________
☐ Yes	☐ No	History of aneurysm	________
☐ Yes	☐ No	Claudication (cramping in legs while walking)	________
☐ Yes	☐ No	Phlebitis (cloths in legs)	________
☐ Yes	☐ No	Pulmonary embolism (clots in lungs)	________
☐ Yes	☐ No	Any other type of vascular disease	________

VII. Gastrointestinal System Review

Yes	No		Date
☐ Yes	☐ No	Nausea/vomiting	______
☐ Yes	☐ No	Loss of Appetite	______
☐ Yes	☐ No	Reflux (heartburn)	______
☐ Yes	☐ No	Trouble swallowing liquids	______
☐ Yes	☐ No	Trouble swallowing solids	______
☐ Yes	☐ No	Abdominal pain	______
☐ Yes	☐ No	Constipation	______
☐ Yes	☐ No	Diarrhea	______
☐ Yes	☐ No	Blood in stools	______
☐ Yes	☐ No	Esophageal disease	______

VIII. Gastrointestinal Testing

Yes	No		
☐ Yes	☐ No	Upper/Lower endoscopy (EGD/Colonoscopy)	______
☐ Yes	☐ No	Biopsy	______
☐ Yes	☐ No	Swallowing studies	______

THE FOLLOWING QUESTION SRELATE TO HEALTH PROBLEMS YOU HAVE OR HAVE HAD IN THE PAST. (Please circle the appropriate conditions)

Yes	No	
☐ Yes	☐ No	Endocrine/hormonal (thyroid disease, adrenal disease, goiter)
☐ Yes	☐ No	Neurological (seizures, vertigo, previous stroke, aneurysm, etc)
☐ Yes	☐ No	Ophthalmologic (glaucoma, cataracts, visual impairment, etc)
☐ Yes	☐ No	Ear, nose, throat (snoring, hearing aids, sinus, hoarseness, nose
☐ Yes	☐ No	bleeds, etc)
☐ Yes	☐ No	Renal/kidney (renal insufficiency, dialysis, kidney stones, etc)
☐ Yes	☐ No	Urological (prostate disease, frequent bladder infections,
☐ Yes	☐ No	impotence, etc)
☐ Yes	☐ No	Immunological (gout, rheumatoid arthritis, lupus, etc)
☐ Yes	☐ No	Infectious (aids, hepatitis, TB, syphilis, endocarditis, etc)
☐ Yes	☐ No	Hematologic (anemia, bleeding/clotting problems, leukemia etc)
☐ Yes	☐ No	Psychological (depression, anxiety, panic attacks, anorexia, bulimia, etc)
☐ Yes	☐ No	Physical disability (problems with walking, etc)
☐ Yes	☐ No	Skin (psoriasis, eczema, petichiae, etc)
☐ Yes	☐ No	Vascular (varicose veins, aortic aneurysm, etc)
☐ Yes	☐ No	Musculoskeletal (joint pain, arthritis, weakness etc)

I have reviewed the above information with the patient:

______________________________ (PA)

______________________________ (M.D.)

______________ Date