Baylor Scott & White
SURGICAL ONCOLOGY SPECIALISTS
A member of HealthTexas Provider Network

Name: _____ **Age:** _____ **Date of Birth:** _____
Contact Information: Phone: _____ Email: _____
Primary Doctor: _____ Phone: _____
Referring Doctor: _____ Phone: _____
Why were your referred to a surgeon? _____

What **surgeries** have you had in the past? What year were they done?
(1) _____ (5) _____
(2) _____ (6) _____
(3) _____ (7) _____
(4) _____ (8) _____

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? _____
Who is your cardiologist? _____ Phone Number: _____

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? _____
What types and who? _____

Social History
Do you **smoke** (yes or no)? How much (packs / 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 & frequency)
(1) _____ (5) _____
(2) _____ (6) _____
(3) _____ (7) _____
(4) _____ (8) _____
Do you take insulin or steroids (yes or no)?

Allergies (Include the type of reaction)
(1) _____
(2) _____
(3) _____
(4) _____

Physician Notes

Examination (pertinent findings) (completed by the physician)
CONST:
EYES:
HEENT:
NECK/THYROID:
RESP:
C/V:
CHEST/BREAST:
ABD:
GU:
LYMPHATIC:
MUSC/SKEL
SKIN:
NEURO:
PSYCH:

Baylor Scott & White
SURGICAL ONCOLOGY SPECIALISTS
A member of HealthTexas Provider Network

Have you gained or lost weight?	Gained / Lost
If "yes," how much weight and over what period of time?	Amount: _____ Time: _____
Do you ever have fever or chills or night sweats?	Yes / No
Do you have a normal appetite?	Yes / No
Do you have nausea or vomiting?	Yes / No
Do you have diarrhea?	Yes / No
Do you have constipation?	Yes / No
Have you had a change in your bowel habits?	Yes / No
Do you ever notice blood in your stool?	Yes / No
Do you have heartburn or reflux symptoms?	Yes / No
Do you have any difficulty swallowing?	Yes / No
Do you have any hoarseness or change in your voice?	Yes / No
Do you ever have shortness of breath when resting or sleeping?	Yes / No
Have you ever had pneumonia?	Yes / No When? _____
Do you have sleep apnea?	Yes / No
Do you have a persistent cough?	Yes / No
Do you ever have chest pain, at rest or with exertion?	Yes / No
Have you had a heart attack, especially in the last six months?	Yes / No
Have you ever had a "stress test" or "heart cath"?	Yes / No When? _____
Have you ever had heart angioplasty or stents or heart surgery?	Yes / No When? _____
Do you ever have irregular heart beats?	Yes / No
Have you ever been hospitalized with congestive heart failure?	Yes / No When? _____
Do you have swelling of your legs?	Yes / No
Have you ever had a blood clot in your legs or lungs?	Yes / No
Have you ever had surgery to improve blood flow in your legs?	Yes / No
Have you ever had hepatitis or jaundice?	Yes / No
Do you have any difficulty urinating?	Yes / No
Are you on dialysis? What type? _____ What days? _____	Yes / No
Do you have any family or personal history of easy bruising?	Yes / No
Have you or a family member ever had difficulty with anesthesia?	Yes / No
Do you have any history of stroke?	Yes / No
If yes, do you still have any persistent weakness or deficit?	Yes / No
Do you perform routine self breast examinations?	Yes / No
Do you have any nipple discharge?	Yes / No
Have you received chemotherapy or radiation in the last 30 days?	Yes / No
Have you had any surgery in the last 30 days?	Yes / No
Do you have any open wounds?	Yes / No
Do you have anxiety or depression?	Yes / No
Do you live independently?	Yes / No

Physician Signature: _____ **Date:** _____