Surgical Consultants of Dallas, L.L.C

## New Patient Medical History Questionnaire

Please complete the following information regarding your medical condition. Please return the questionnaire with your insurance authorization for your surgical consultation and your insurance card.

Name: ________________________________________ Date of Birth: _____/_____/_____ Age: ____________

Home Phone: __________________________________ Cell Phone: ____________________________________

Email Address: _________________________________ Primary Language: ______________________________

Address: ______________________________________ City/State/Zip Code: ____________________________

Social Security Number: __________________________ Driver's License Number/State: ____________________

Occupation: ____________________________________ Employer's Name: ______________________________

Employer's Address: ____________________________ Business Phone: _______________________________

Marital Status: _________________________________ Number of Children: ____________________________

Spouse's Name: ________________________________ Spouse's Employer: _____________________________

Spouse's Phone: ________________________________

Emergency Contact: _____________________________________________________________
(other than above)
Relationship: __________________________________ Phone Number: ________________________________

### Medical Insurance Information

Primary Insurance Company: _____________________ Policy Holder and DOB: __________________________

Subscriber Number: _____________________________ Group Number: _________________________________

Insurance Company Address: _______________________________________________________________________

Secondary Insurance Company: ___________________ Policy Holder and DOB: __________________________
(if applicable)
Subscriber Number: _____________________________ Group Number:_________________________________

Insurance Company Address:_______________________________________________________________________

Is the reason for this consultation work-related? ________________________________________________________

Surgical Consultants of Dallas, LLC
7777 Forest Lane Suite A-331
Dallas, TX 75230
(972) 566-7860
www.surgicalconsultantsofdallas.com

Patient Name:_______________________________________________________ DOB: _________________

**Surgeon**

☐ Christopher Bell, MD ☐ Da-Shu "Sue" Jiang, MD ☐ Dina Madni, MD ☐ Michael Sutker, MD

**Reason for Visit**

Please describe the reason for your visit in detail.
You may be asked to fill out additional forms regarding your current condition at the time of your visit:

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

**Referring Providers**

Please provide the name of the doctor who referred you, your primary care physician (PCP), and any other doctor from whom you are receiving care.

Doctor who referred you:________________________ Referring Doctor Phone Number: _________________

Primary Care Physician: _________________________ PCP Phone Number: ___________________________

Additional Physician and Specialty: ________________ Phone Number: ______________________________

Additional Physician and Specialty: ________________ Phone Number: ______________________________

How did you find our practice?

☐ Friend/relative ☐ PCP or other provider ☐ Insurance

☐ Social Media: ☐ Website: ☐ TV/radio/magazine:
____________________________ ____________________________ ______________________________

☐ Other: _______________________

**Pharmacy**

Pharmacy Name: __________________________ Phone Number: ______________________________

Pharmacy Address: __________________________________________________________________________

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Patient Name:_______________________________________________________ DOB: __________________

**Past Medical History**

Please check any illnesses you have had in the past.

☐ Allergies (hay fever)
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Bleeding conditions
☐ Blood clots in the legs (DVT)
☐ Blood clots in the lungs (PE)
☐ Blood disorders
☐ Blood transfusion
☐ Bronchitis, emphysema, COPD
☐ Cancer (list type below)
☐ Congestive Heart Failure
☐ Depression
☐ Diabetes
☐ Endometriosis
☐ Fatty Liver Disease
☐ Gallstones or Gallbladder disease
☐ Gastro-esophageal Reflux Disease (GERD)
☐ Gout
☐ Heart disease (e.g. coronary artery disease, heart attack, arrhythmia)
☐ Hepatitis
☐ High cholesterol (hyperlipidemia)
☐ High blood pressure (hypertension)
☐ HIV/AIDS
☐ Intertrigo
☐ Intestinal disease (e.g. diverticulitis, Crohn's disease)
☐ Intracranial hypertension (normal pressure hydrocephalus)
☐ Kidney disease
☐ Liver disease
☐ Migraines
☐ Muscle or nerve disease
☐ Obstructive sleep apnea
☐ Osteoporosis
☐ Seizures
☐ Skin disease
☐ Stroke
☐ Substance Abuse
☐ Thyroid disease
☐ Ulcers
☐ Urinary Incontinence
☐ Other: ______________________________

If any of your conditions require further explanation, please describe below:

_____________________________________________________________________________________

_____________________________________________________________________________________

**Hospitalizations**

If you have ever been hospitalized, please list the date(s) and reasons.

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

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Patient Name:_______________________________________________________ DOB: __________________

**Past Surgical History**

Please check any operation you have had and list the date performed.

☐ Appendectomy
☐ Colonoscopy
☐ Eye Surgery
☐ Intestinal Surgery
☐ Tubal Ligation
☐ Breast Surgery
☐ Cosmetic Surgery
☐ Fracture Surgery
☐ Joint Replacement
☐ Vasectomy
☐ Cholecystectomy (gallbladder removal)
☐ Cesarean section (C-section)
☐ Hernia Repair
☐ Prostate Surgery
☐ Weight Loss Surgery

Other: _______________________________________________________________________________________

If any of your surgeries require further explanation, please describe below:

_____________________________________________________________________________________________

_____________________________________________________________________________________________

**Medications**

| *Medication* | *Dose* | *How Often* | *Reason* | *Prescriber* |
|---|---|---|---|---|
| | | | | |
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**Allergies**

Have you had a reaction to any of the following: ☐ Latex ☐ Iodine ☐ IV contrast

Are you allergic to any medications? Please list name of medication and your reaction.

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Patient Name:_______________________________________________________ DOB: _________________

**Family History**

| | Living | Deceased | Bleeding Disorder | Cancer | Diabetes | Heart Disease | High Blood Pressure | Kidney Disease | Liver Diease | Mental Illness | Obesity | Stroke | Thyroid Disease |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mother | | | | | | | | | | | | | |
| Father | | | | | | | | | | | | | |
| Sister | | | | | | | | | | | | | |
| Brother | | | | | | | | | | | | | |
| Son | | | | | | | | | | | | | |
| Daughter | | | | | | | | | | | | | |
| Maternal Grandmother | | | | | | | | | | | | | |
| Maternal Grandfather | | | | | | | | | | | | | |
| Paternal Grandmother | | | | | | | | | | | | | |
| Paternal Grandfather | | | | | | | | | | | | | |
| Cousin | | | | | | | | | | | | | |
| Other | | | | | | | | | | | | | |

If any of your family history requires further explanation, please describe below:

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

**Surgical Consultants of Dallas, L.L.C**

Patient Name:_______________________________________________ DOB: ___________________

## Social History

Please check any of the following if they pertain to you:

☐ Live alone ☐ Have difficulty carrying a 10 lb bag ☐ Have difficulty dressing

☐ Receive special care at home ☐ Have had more than 3 falls in the past year

Do you drink alcohol? ☐ Yes ☐ No

If so, how much per week? ________ glasses of wine ________ cans of beer ________ shots of liquor

Do you use tobacco? ☐ Yes ☐ No

How many packs per day? ________ How many years have you smoked? ______________________________

Do you use recreational drugs? ☐ Yes ☐ No

If yes, which drugs and how often: ______________________________________________________________

What kind of physical activities do you participate in? ___________________________________________

## Gynecologic History (*women only)*

Are you currently pregnant? ______________________

What is the date of your last menstrual period? ______

Do you have irregular periods? ____________________

Have you gone through menopause? _______________
If so, at what age? ____________

At what age was your first period? _________________

Have you had problems with infertility? _____________

How many times have you been pregnant? __________

How many children do you have? __________________

Have you used birth control pills? __________________

Have you used hormone replacement therapy? ______

When was your most recent Pap smear? ____________

When was your most recent mammogram? __________

Patient Name:________________________________________________________ DOB: ___________________

**Review of Systems**

Please check or circle any of the following if you have experienced them in the past 3 months.

| | | | |
|---|---|---|---|
| *General* | ☐ Fevers<br>☐ Fatigue | ☐ Chills<br>☐ Sweating | ☐ Weight Loss<br>☐ Weakness |
| *Skin* | ☐ Rash | ☐ Itching | |
| *Head, Eyes, Ears, Nose, Throat* | ☐ Headaches<br>☐ Ear Pain<br>☐ Nasal Congestion<br>☐ Double Vision<br>☐ Eye Discharge | ☐ Hearing Loss<br>☐ Ear Discharge<br>☐ Sore Throat<br>☐ Photophobia<br>☐ Eye Redness | ☐ Tinnitus (ringing)<br>☐ Nosebleeds<br>☐ Blurred Vision<br>☐ Eye Pain |
| *Cardiovascular* | ☐ Chest Pain<br>☐ Leg or ankle swelling | ☐ Palpitations<br>☐ Difficulty breathing while asleep | ☐ Claudication<br>☐ Difficulty breathing while laying flat |
| *Pulmonary* | ☐ Cough ☐ Hemoptysis (coughing blood) | ☐ Shortness of breath | ☐ Wheezing |
| *Abdomen* | ☐ Heartburn<br>☐ Abdominal Pain<br>☐ Bright red blood in stool | ☐ Nausea<br>☐ Diarrhea<br>☐ Melena (dark red blood in stool) | ☐ Vomiting<br>☐ Constipation |
| *Urinary* | ☐ Dysuria (burning with urination)<br>☐ Frequency (urinating often) | ☐ Flank Pain<br>☐ Urgency (need to urinate quickly) | ☐ Hematuria (blood in urine) |
| *Musculoskeletal* | ☐ Myalgia (crampy muscle pain)<br>☐ Joint Pain (specify) | ☐ Neck Pain ☐ Back Pain | ☐ Falls |
| *Blood* | ☐ Easy bruising or bleeding | ☐ Seasonal allergies | |
| *Neurologic* | ☐ Dizziness<br>☐ Sensory changes<br>☐ Seizures | ☐ Tingling<br>☐ Speech change<br>☐ Loss of Consciousness | ☐ Tremor<br>☐ Focal weakness |
| *Psychiatric* | ☐ Depression<br>☐ Anxiety<br>☐ Suicidal Thoughts | ☐ Substance Abuse<br>☐ Insomnia | ☐ Hallucinations<br>☐ Memory Loss |

If any of your symptoms require further explanation, please describe below:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

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