Texas
Laparoscopic
Consultants

Consent To Release Medical Information

I give authorization for the staff of Texas Laparoscopic Consultants, Dr. Yu, and Dr. Scarborough to communicate medical information to the below listed persons. These communications include, but are not limited to: information about the procedure I am having, the scheduling of pre-operative testing, the outcome of my surgery and condition, information regarding any complications, and my post-operative care. Information discussed could also include any additional health conditions (such as psychiatric problems, substance abuse, and or HIV status) as related to my current condition and medical treatment.

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

Printed Name	Date
Signature	
Witness	Date

_______ I DO NOT AUTHORIZE THE RELEASE OF ANY INFORMATION

General Surgery Patient History Questionnaire

Demographics: *Please fill out completely*

First Name:________________________ Address:________________________

Middle Name:________________________ City, State Zip: ________________________

Last Name:________________________ *Email Address:________________________*

***Do you consent for TLC to email you clinical information such as lab reports?** Yes No ________**Initials**

***Do you consent for TLC to send a text to your mobile phone about appointment notifications?** Yes No ________**Initials**

Nickname / Preferred Name:________________ Cell Phone: ________________ Ok to leave voicemail? Y N

Maiden Name:________________________ Home Phone: ________________ Ok to leave voicemail? Y N

Gender: Male Female Other Phone:________________ Ok to leave voicemail? Y N

Date of Birth:________________________ Social Security Number:________________________

Marital Status: Single Married Partnered Separated Divorced Widowed

Ethnicity: African American Arabic Asian Caucasian Hispanic Native American Other

Highest Level of Education: HS/GED Associate Bachelor Master Professional Doctoral

Employment: Full-time Part-time Homemaker Student Retired Disabled Unemployed

If disabled, specify the year and the cause: Year:____________ Cause:________________

Patient Occupation (indicate if student):____

Employer:________________________________ Years Employed:________________

Employer's Address: ____

Spouse's Name:________________________________ Spouse's Date of Birth:________________

Spouse employment: Full-time Part-time Homemaker Student Retired Disabled Unemployed

Spouse's occupation (indicate if student):____

Spouse's Employer:________________________________ Years Employed:____________

Use spouse as an emergency contact? Yes No Phone:________________________

Emergency Contact #1:

First Name:________________________

Last Name:________________________

Relation to you:________________________

Phone:________________________

Emergency Contact #2:

First Name:________________________

Last Name:________________________

Relation to you:________________________

Phone:________________________

Referral and Visit Information

Reason for Visit (i.e. why are you seeing TLC today?): ______________________________

____

____

How did you hear about TLC Surgery? Internet/Facebook Magazine Newspaper Other Patient

Our Website Television Yellow Pages Physician or Hospital Referral: ____________

Primary Care Physician Information

Name: ______________________________

Phone: ____________________ Address: ____________________

Fax: ____________________ City, State Zip: ____________________

Do you consent for TLC to send medical records to your PCP? Yes No ________ **Initials**

Specialist Physician Information: *if you regularly see a specialist*

Name: ____________________ Type: ____________________

Phone: ____________________ Address: ____________________

Fax: ____________________ City, State Zip: ____________________

Primary Insurance Information: *Please fill out completely*

Insurance Company: ____________________ Policy Number: ____________________

Full Name of Cardholder: ____________________ Group Number: ____________________

Cardholder's DOB: ____________________ Effective Date: ____________________

Cardholder's SS#: ____________________ Termination Date: ____________________

Cardholder's Employer: ____________________ Insured ID: ____________________

Notes: ____________________ Insurance Phone#: ____________________

Relationship to Cardholder: Self Spouse Child Other: ____________________

Is this plan: Cobra Medicare Medicaid Disability Workman's Comp None

Secondary Insurance Information: *Please fill out completely*

Insurance Company: ____________________ Policy Number: ____________________

Full Name of Cardholder: ____________________ Group Number: ____________________

Cardholder's DOB: ____________________ Effective Date: ____________________

Cardholder's SS#: ____________________ Termination Date: ____________________

Cardholder's Employer: ____________________ Insured ID: ____________________

Notes: ____________________ Insurance Phone#: ____________________

Relationship to Cardholder: Self Spouse Child Other: ____________________

Is this plan: Cobra Medicare Medicaid Disability Workman's Comp None

Surgical/ Hospitalization History: *Please check or list all surgeries you have had*

Surgery	☐	Month	Year
Gallbladder (Open)	☐	______	______
Gallbladder (Laparoscopic)	☐	______	______
Appendectomy	☐	______	______
Hernia (Body Location: ________________)	☐	______	______
Hernia (Body Location: ________________)	☐	______	______
Hysterectomy (Uterus removed vaginally)	☐	______	______
Hysterectomy (Uterus removed abdominally)	☐	______	______
Ovary Surgery	☐	______	______
Cesarean Section	☐	______	______
Tubal Ligation:	☐	______	______
Left Breast Biopsy	☐	______	______
Right Breast Biopsy	☐	______	______
Back	☐	______	______
Right Knee	☐	______	______
Left Knee	☐	______	______
Tonsillectomy	☐	______	______
Heart Surgery	☐	______	______
Kidney Transplant	☐	______	______
Liver Transplant	☐	______	______
Pancreas Transplant	☐	______	______
Other: ____________________	☐	______	______
Other: ____________________	☐	______	______

Social History: *Please select all that apply*

Alcohol Use: Yes No

Drinks per week: ________

Tobacco Use: Yes No

Packs per week: ________

Substance Abuse: Yes No

Uses per week: ________ (RX or illegal)

Cans per week: ________

Family History: Please check all that apply

Obesity	☐	Kidney Disease	☐
Heart Disease	☐	Diabetes Mellitus	☐
High Blood Pressure	☐	Alcoholism	☐
Liver Problems	☐	Lung Problems	☐
Bleeding Disorder	☐	Gallstones	☐
Mental Illness	☐	Malignant hyperthermia	☐
Are you adopted?	☐	Cancer	☐

Please describe the person(s) and the type(s) of cancer present in your family:

____

____

Drug Allergies: ***Please list all DRUG allergies***

Name of Medication	*Reaction it Causes*
1.	
2.	
3.	
4.	
5.	
6.	

Skin Allergies: ***please circle all SKIN allergies***

Circle all that apply	*Reaction it Causes*
1. Latex	
2. Iodine	
3. Band-Aid Bandages or Adhesive	
4. Other:	

Medications, Vitamins, & Minerals: ***Please check / list all medications that you currently use***

	Name	*Dosage*	*Frequency*	*Indication*
☐	Lisinopril	______	______	Hypertension
☐	Levothyroxine / Synthroid	______	______	Hypothyroidism
☐	Simvastatin / Zocor	______	______	High Cholesterol
☐	Amlodipine / Norvasc	______	______	Hypertension / Angina
☐	Metformin / Glucophage	______	______	Diabetes
☐	Hydrochlorothiazide	______	______	Hypertension

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______
7. ______
8. ______
9. ______
10. ______
11. ______
12. ______
13. ______
14. ______
15. ______

*Frequency:
QD: 1x daily BID: 2x daily TID: 3x daily QID: 4x daily QOD: 1x daily, every other day

Pharmacy Information:

Name: ______

Address: ______

Phone Number: ______

Review of Systems: ***Check all the health problems you have had or are currently experiencing***

****Please note that if you are not familiar with a listed condition, then it may not pertain to you.*

Cardiovascular

- Heart Attack ☐
- Rhythm disturbance/ palpitations ☐
- High Blood Pressure ☐
- Varicose Veins ☐
- Phlebitis ☐
- Heart bypass/valve replacement ☐
- Clogged Heart Arteries ☐
- Heart Murmur ☐
- Other: ____________________ ☐
- Angina (chest pain with activity) ☐
- Congestive Heart Failure ☐
- Ankle Swelling ☐
- Cramping in legs when walking ☐
- Ankle/ leg ulcers ☐
- Pacemaker ☐
- Rheumatic fever/ valve damage ☐
- Irregular heartbeat ☐

Respiratory

- Asthma ☐
- Bronchitis ☐
- Chronic Cough ☐
- Use of CPAP or oxygen supplement ☐
- Pulmonary Embolism ☐
- Cough up blood ☐
- Awaken at Night ☐
- Sleep Apnea ☐
- Lung Cancer ☐
- Emphysema ☐
- Pneumonia ☐
- Short of Breath ☐
- Tuberculosis ☐
- Hypoventilation Syndrome ☐
- Snoring ☐
- Daytime Drowsiness ☐
- Lung Surgery ☐
- Other: ____________________ ☐

Endocrine

- Hypothyroid (low) ☐
- Goiter ☐
- Elevated Cholesterol ☐
- Low Blood Sugar ☐
- Diabetes (Needing insulin shots) ☐
- Gout ☐
- Cancer of endocrine gland ☐
- Abnormal facial hair ☐
- Hyperthyroid (high/ overactive) ☐
- Parathyroid ☐
- Elevated Triglycerides ☐
- Diabetes (Managed by diet pills) ☐
- "Prediabetes" w/ elevated blood sugar ☐
- Endocrine gland tumor ☐
- High Calcium level ☐
- Other: ____________________ ☐

Gastrointestinal

Heartburn	☐	Hiatal Hernia	☐
Abdominal Hernia	☐	Ulcers	☐
Diarrhea	☐	Blood in Stool	☐
Change in bowel habit	☐	Constipation	☐
Irritable Bowel	☐	Colitis	☐
Crohn's	☐	Hemorrhoids	☐
Fissure	☐	Rectal Bleeding	☐
Black, tarry stool	☐	Polyps	☐
Abdominal pain	☐	Enlarged Liver	☐
Cirrhosis/ hepatitis	☐	Gallbladder problems	☐
Jaundice	☐	Pancreatic disease	☐
Unusual vomiting	☐	Surgery	☐
Cancer	☐	Other: ____________________	☐

Bladder/ Kidney

Kidney Stones	☐	Blood in Urine	☐
Loss of bladder control (leakage)	☐	Kidney Failure	☐
For men: PSA in last year?	☐	Prostate Problems	☐
Trouble starting urine	☐	Burning on Urine	☐
Surgery	☐	Cancer	☐

Gynecologic *(for women only)*

Problems conceiving (infertility)	☐	Currently pregnant	☐
Uterine/ Ovarian Cancer	☐	Surgery	☐
Menstrual irregularity	☐	Menstrual pain	☐
Excessively heavy periods	☐	Abdominal pain	☐

Age started menses: ____________ Date of last menstrual period: ________________

Number of pregnancies: __________ Date of last pap smear: ____________________

Number of children: ____________ Date of menopause onset: __________________

Number of miscarriages or abortions: __________

Musculoskeletal

Arthritis	☐	Neck Pain	☐
Shoulder Pain	☐	Wrist Pain	☐
Back Pain	☐	Hip Pain	☐
Knee Pain	☐	Ankle Pain	☐
Foot Pain	☐	Heel Pain	☐
Ball of foot/toe pain	☐	plantar fasciitis	☐
Carpal tunnel syndrome	☐	Lupus	☐
Scleroderma	☐	Sciatica	☐
Autoimmune disease	☐	Muscle pain/spasm	☐
Fibromyalgia	☐	Broken Bones	☐
Joint replacement	☐	Nerve injury	☐
Muscular dystrophy	☐	Surgery	☐
Cancer	☐	Other: ____________________	☐

Head And Neck

Wear Contacts/ Glasses	☐	Vision Problems	☐
Hearing Problems	☐	Sinus Drainage	☐
Neck Lumps	☐	Swallowing Difficulty	☐
Dentures/ Partial	☐	Oral Sores	☐
Hoarseness	☐	Head/ Neck Surgery	☐
Cancer	☐	Other: ____________________	☐

Neurologic

Migraine Headaches	☐	Balance Disturbance	☐
Seizures or Convulsions	☐	Weakness	☐
Stroke	☐	Alzheimer's	☐
Pseudotumor cerebri	☐	Multiple Sclerosis	☐
Frequent severe headaches	☐	Knocked Unconscious	☐
Surgery	☐	Cancer	☐

Breast

Lumps	☐	Pain	☐
Fibrocystic disease	☐	Nipple discharge	☐
Surgery	☐	Cancer	☐

Skin

Rashes under skin folds	☐	Keloids (excessively raised scars)	☐
Poor wound healing	☐	Frequent skin infections	☐
Surgery	☐	Cancer	☐

Blood

Anemia (iron deficient)	☐	Anemia (vitamin B12 deficient)	☐
Exposed to HIV	☐	Diagnosed with HIV / AIDS	☐
Low platelets (thrombocytopenia)	☐	Received blood transfusion	☐
Hepatitis	☐	Abused intravenous drugs	☐
Lymphoma	☐	Swollen lymph nodes	☐
Superficial blood clot in leg	☐	Deep blood clot in leg	☐
Blood clot in lungs	☐	Bleeding disorder	☐
Would you accept a blood transfusion? Yes No		Blood thinning medicine use	☐

Psychiatric

Anxiety	☐	Depression	☐
Anorexia	☐	Bulimia	☐
Bipolar disorder	☐	Alcoholism	☐
Drug dependency	☐	Schizophrenia	☐
Other psychiatric problems	☐		

Hospitalization for psychiatric problems ☐

Have you ever been in a psychiatric hospital? ☐

Have you ever attempted suicide? ☐

Have you ever been physically abused? ☐

Have you ever seen a psychiatrist or counselor? ☐

Are you currently seeing a psychiatrist or counselor? ☐

Have you ever taken medications for psychiatric problems or for depression? ☐

Have you ever been in a chemical dependency program? ☐

Constitutional

Fevers	☐	Night Sweats	☐
Anemia	☐	Weight Loss	☐
Chronic Fatigue	☐	Hair Loss	☐

Thank you for filling out the questionnaire honestly and completely.

Heartburn/Reflux/Gerd Symptoms

Check all that apply:

- ☐ Chest Pain/Discomfort
- ☐ Long term Cough, Sore Throat
- ☐ Difficulty Swallowing
- ☐ Bad Breath/Dental Erosion
- ☐ Stomach Fullness or Bloating/Gas
- ☐ Upper Abdominal Discomfort
- ☐ Asthma/Shortness of Breath
- ☐ Sudden Saliva
- ☐ Burping
- ☐ Burning Back of Throat
- ☐ Feeling of Lump in Throat
- ☐ Regurgitation
- ☐ Nausea After Eating

OTHER SYMPTOMS? ____________________

Check the foods or beverages that worsen your Heartburn/Reflex/Gerd Symptoms:

- ☐ Spicy Foods
- ☐ Citrus Fruits
- ☐ Milk
- ☐ High-Fat Foods
- ☐ Chocolate
- ☐ Caffeine
- ☐ Salty Foods
- ☐ Sodas and Carbonated Beverages
- ☐ Alcohol

Have you made any diet modifications?

- ☐ Yes, I have reduced or completely eliminated above listed food from diet.
- ☐ No.

Has your diet modification been effective?

- ☐ Yes.
- ☐ Somewhat, but still requires medication.
- ☐ Not at all.

Other methods attempted to improve Heartburn/Reflux/Gerd Symptoms:

- ☐ Changing Position in Bed
- ☐ Avoid Tight Clothing
- ☐ Sleeps in a Reclined Position
- ☐ Weight Loss
- ☐ New Bed/or Adjustable Mattres

OTHER METHODS? ____________________

How often do you use the following medications:

	1-4 Times a Week	Daily	A Few Times a Day
Alkas-Seltzer	☐	☐	☐
Pepcid	☐	☐	☐
Zantac	☐	☐	☐
Tagamet	☐	☐	☐
Maalox	☐	☐	☐
Mylanta	☐	☐	☐
Pepto-Bismol	☐	☐	☐
Rolaids	☐	☐	☐
Tums	☐	☐	☐

How long have you been on the following medications:

	0-6 Months	6 Months to 1 Year	Over 1 Year
Dexilant	☐	☐	☐
Nexium	☐	☐	☐
Prevacid	☐	☐	☐
Prilosec, Zegerid	☐	☐	☐
Protonix	☐	☐	☐
Aciphex	☐	☐	☐
Reglan	☐	☐	☐