NORTHSIDE THORACIC SURGERY
A Northside Network Provider

Patient Name_____ **Patient Date of Birth**_____

Date of Service _____ **Referring Provider** _____

Primary Care Provider (if not same as referring provider) _____

Type of Advance Directive (Please circle one):

Living Will? Yes No

Medical Durable Power of Attorney? Yes No

Allergies

Does the patient have any allergies? Yes No

If yes, please list all allergies separated by commas: _____

_____

Medications

Please list all medications that you are currently taking including over-the-counter medications and supplements. Please also indicate dosage and frequency: _____

_____

_____

Past Medical History Please circle all that apply

Neurological:

None Stroke Concussion Peripheral Neuropathy Epilepsy/Seizures

Cardiovascular:

None Heart Attack High Blood Pressure Coronary Artery Disease Elevated Cholesterol
A-Fib/Irregular Heartbeat Pacemaker

Kidney:

None Renal Insufficiency Kidney Stones One Kidney/Abnormal Kidney

Gastrointestinal:

None Ulcers Reflux Intolerance to NSAIDS

Skin:

None History of Skin Rash Psoriasis

Endocrine:

None Diabetes Prednisone Use Thyroid Disease

Pulmonary:

None Asthma COPD Emphysema Pulmonary Embolism

Infectious:

None Hepatitis B Hepatitis C HIV/AIDS MRSA Recent Tick Bite TB

Musculoskeletal:

None Fibromyalgia Gout Osteoarthritis Osteoporosis Rheumatoid Arthritis

Hematological:

None Anemia Bleeding Problems Blood Clots Blood Transfusion

Cancer:

Yes No

Problem(s) Not Listed: _____

Surgical History

Has the patient ever had a surgery or an invasive procedure? Yes No

If yes, please list the procedures and corresponding dates of the procedures separated by commas: _____

_____

Tobacco/Vaping History

Do you have a history of tobacco use/vaping? Yes No

If yes, have you ever used any of the following forms of tobacco? (Circle all that apply)

None Smoking Tobacco Smokeless Tobacco Vaping

Smoking Tobacco:

Do you currently smoke? Yes No

Smoking tobacco material used: _____

What age did you start smoking? _____

How much did you/do you smoke per day?

Less than half a pack per day Half a pack per day One pack per day Two packs per day

Three or more packs per day

How old were you when you quit smoking?_____

Smokeless Tobacco:

Do you currently use smokeless tobacco? Yes No

Smokeless tobacco material used:_____

What age did you start using smokeless tobacco? _____

How much smokeless tobacco did you/do you use per day?_____

How old were you when you quite using smokeless tobacco?_____

Vape:

Do you currently vape? Yes No

Type of material being vaped:_____

What age did you start vaping? _____

How much did you/do you vape per day?_____

How old were you when you quit vaping?_____

Alcohol History

Alcohol Use- Please circle all that apply

Never Current Past

Alcohol Type

N/A Beer Liquor Wine Other: _____

How often does/did the patient drink alcohol?

N/A 1-2 times a year 1-2 times a month 1-2 times a week 3-5 times a week Daily
Several times daily

Substance Use History

Substance Use- Please circle all that apply

Never Current Past

Substance Use Type

N/A Amphetamines Cocaine Ecstasy LSD/Hallucinogens Heroin Marijuana
Inhalants/Glues/Solvents Methamphetamines Prescription Medication Other: _____

Substance use Frequency

N/A 1-2 times a year 1-2 times a month 1-2 times a week 3-5 times a week Daily
Several times daily

Living Condition

Who do you live with? (Circle all that apply)

Alone Children Father Mother Siblings Significant Other Spouse
Other: _____

Patient's Marital Status:

Single Married Divorced Separated Other: _____

Spouse's first and last name: _____

Living Situation:

Home/Independent Home with assistance Hospice Homeless/Shelter Other:_____

Employment/School Status:

Employed Part Time Retired Student Unemployed Other:_____

Employment/School Description: _____

Exercise

How many days per week do you exercise? _____

Select the item that best describes the patient's level of activity:

Light Moderate Vigorous Other: _____

Exercise Type:

N/A Running Swimming Walking Weight Lifting Yoga Other:_____

Family History

Please circle all that apply to your parents, siblings, and grandparents:

None Unknown Diabetes Blood Clots Hip/Spine Fracture Heart Disease Stroke
High Blood Pressure Bleeding Problems Cancer Osteoporosis Lung Disease
Kidney Disease Sickle Cell Anemia Other: _____

Please list the relationship corresponding to the selected conditions above _____

_____

_____

PLEASE FILL OUT THE INFORMATION BELOW FOR ALL DOCTORS WHO HAVE BEEN RELEVANT TO YOUR TREATMENT:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

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