WELLSTAR THORACIC SURGERY
WILLIAM R. MAYFIELD, M.D., F.A.C.S.
WARD V. HOUCK, M.D., F.A.C.S.
THERESA LUU, M.D.

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**PATIENT NAME:** ______________________________________________

Because it is important for us to honor the confidentiality between patient and physician, you are asked to consider whether you wish for your medical concerns to be discussed with family members, should your doctor be contacted by them.

Please realize, of course, that by law it is required that we release requested medical information to your insurance company, to inquiries from Medicare, Medicaid and Social Security Administration, and to others specifically demanded.

Discuss my medical concerns/PHI with any immediate family member **EXCEPT** those listed below:

______________________________ ______________________________

______________________________ ______________________________

I understand that a written request by me will be required to alter the above, and I will note specifically with whom my doctor may discuss my case.

Signature of Patient ______________________________ Date ______________

Signature of Parent/Legal Guardian ______________________________ Date ______________

**I understand that signing below will allow Wellstar Thoracic Surgery Associates to:**

→ Completion of any Disability Paperwork

→ Completion of release form to return to work/school

→ Disclosure of treatment dates, prognoses, diagnoses, CPT codes, commencement date of condition being treated for, description of services performed, release of progress notes (if requested), and release dates for work/school

→ Completion of forms for Family Leave Act

Signature of Patient ______________________________ Date ______________

Signature of Parent/Legal Guardian ______________________________ Date ______________

# WELLSTAR THORACIC SURGERY ASSOCIATES LLC

THERESA D. LUU MD    WILLIAM R. MAYFIELD, M.D.    WARD V. HOUCK, M.D.

Patient Initial Visit Form

Date:______________ Name:______________________________________________

Age:______________ Date of Birth:____________________ Sex:____________________

Referring Physician:______________________________________________

Other Physicians that you regularly see:

Oncologist______________________________ phone#______________________________

Cardiologist______________________________ phone #______________________________

Pulmonologist______________________________ phone #______________________________

Primary Care______________________________ phone #______________________________

What is the reason for your visit to our office?______________________________

When did you first become aware of the problem you are being seen for today?______________________________

**THE FOLLOWING QUESTIONS ARE ABOUT YOUR LUNGS. PLEASE CHECK THOSE THAT APPLY**

**SYMPTOMS**

- ☐ Abnormal CT/ Chest X-ray
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Cough
  - ☐ Lots of sputum?
  - ☐ Dry cough?
  - ☐ Coughing up blood
- ☐ Weight loss
- ☐ Fatigue
- ☐ Fever
- ☐ Night sweats
- ☐ mass or nodes in your neck or armpits
- ☐ I have no symptoms
- ☐ Other: ______________________________

______________________________

**TOBACCO USE**

- ☐ I do not and never have smoked
- ☐ I smoke(d) _______ packs per day for _________ yrs
- ☐ I quit smoking in ____________
- ☐ I use chewing tobacco or snuff

**LUNG DISEASES**

- ☐ Emphysema
- ☐ Chronic Bronchitis
- ☐ Asthma
- ☐ I have been on a ventilator for lung failure
- ☐ I use oxygen
- ☐ I use prednisone
- ☐ Sleep Apnea or severe snoring
  - ☐ BIPAP mask
  - ☐ Somnoplasty, palatoplasty
- ☐ Pleurisy
- ☐ Sarcoidosis
- ☐ Tuberculosis exposure
  - ☐ +PPD Date: ____________
  - ☐ Treated? _______ When______________
- ☐ Asbestos exposure
- ☐ Raise birds
- ☐ Exposure to bats, bat houses, or caves
- ☐ lived/visited in the San Joaquin Valley of Central California
- ☐ Lived in the Ohio River Valley
- ☐ I plow my garden
- ☐ Visited Southeast Asia
- ☐ Visited the Amazon River basin

## SOCIAL HISTORY

If you drink alcohol, please estimate approximately ________ beers/drinks per ☐day ☐week
Have you ever experienced difficulty with drug, alcohol or other substance abuse (past or present) ☐yes ☐no
Occupation: ______________________________
Hobbies: ______________________________
Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed
I live with: ______________________________

## FAMILY HISTORY

| Member | Alive / Age | Deceased / Age | Major Illness or Cause of Death |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Siblings | | | |
| | | | |
| | | | |

If you are a female, number of pregnancies ______________ number of deliveries ________________

## REVIEW OF SYSTEMS

**Central Nervous System**
☐seizures ☐stroke
☐chronic severe headaches
☐new onset of severe headaches
☐new onset of weakness/numbness
☐new change in vision or hearing
☐glaucoma
Eye drops:________________

**Genito-Urinary**
☐prostate problems/surgery
☐uterus problems/surgery
☐urinary tract infections
☐kidney stones
☐blood in urine
☐problems with bladder catheters

**Cardiac**
☐high cholesterol
☐angina, chest pains
☐shortness of breath with exercise
☐heart attack
☐heart failure
☐irregular heartbeat
☐fainting
☐palpitations
☐heart murmur
☐angioplasty
Dates:________________
Hospital:________________
☐pacemaker
☐internal defibrillator

**Gastro-Intestinal**
☐ulcers
☐vomiting blood
☐passing blood in stools
☐chronic nausea or vomiting
☐chronic diarrhea
☐constipation
☐hepatitis
☐pancreatitis
☐jaundice
☐gallstones

**Hematology – Oncology**
☐previous cancer
Type:________________
Treatment:________________
Where treated:________________
☐anemia
☐Sickle Cell Anemia/Thallasemia

**Metabolic**
☐thyroid disease
☐menopause, peri-menopause

**Musculo-skeletal**
☐arthritis
☐gout
☐fibromyalgia
☐neck or back problems
☐joint replacement

## PAST MEDICAL HISTORY

| Disease | You | Family Member/Who | Disease | You | Family Member/Who |
|---|---|---|---|---|---|
| Diabetes | ☐ | ☐ | Liver disease | ☐ | ☐ |
| Kidney disease | ☐ | ☐ | Cancer | ☐ | ☐ |
| High blood pressure | ☐ | ☐ | Chemotherapy | ☐ | ☐ |
| Angina (chest pain) | ☐ | ☐ | Radiation Therapy | ☐ | ☐ |
| Heart attack | ☐ | ☐ | Glaucoma | ☐ | ☐ |
| Stroke | ☐ | ☐ | Ulcers | ☐ | ☐ |

## OPERATIONS

**Have you every had a life-threatening reaction to anesthesia?**______________________

Have you ever had a blood transfusion?______________________

Do you have a bleeding disorder or are you a "free bleeder"?______________________

Please list your previous surgical procedures below:

Date:__________ Operation:____________________ Doctor:______________

Date:__________ Operation:____________________ Doctor:______________

Date:__________ Operation:____________________ Doctor:______________

Date:__________ Operation:____________________ Doctor:______________

Hospitalizations for major illnesses or trauma:

Date:__________ Operation:____________________ Doctor:______________

Date:__________ Operation:____________________ Doctor:______________

Date:__________ Operation:____________________ Doctor:______________

Date:__________ Operation:____________________ Doctor:______________

**MEDICATIONS** – Please include any over the counter medications or supplements.

**Do you take any type of blood thinning medication such as Coumadin, Ticlid, Aspirin, Motrin, Plavix, Ibuprofen, or Naprosyn?** ______________________

| Prescription Medications: | Dosage: |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

**IF YOU HAVE A MEDICATION LIST, PLEASE NOTIFY THE FRONT DESK. IF YOU NEED ADDITIONAL SPACE, LIST MEDICATIONS ON BACK OF SHEET.**

**ALLERGIES: (Please list if you are allergic to Latex)**

______________________

______________________

______________________