

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ◆ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment either directly or indirectly.
- ◆ obtain payment from third-party payers
- ◆ conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the opportunity review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

DATE: _____

Signature of patient/person responsible for account

I understand that I am responsible for all fees. I understand the office of Philip J. Straka, M.D. is not currently accepting new insurance patients and will not file any insurance claims on my behalf. I understand that all surgical fees are due prior to surgery being performed.

DATE: _____

Please list those people with whom we may discuss/release medical information to:

To my patients;

I am occasionally asked to review cases and treat patients who have less than satisfactory results from other surgeons. It is my pleasure to try to correct these unsatisfactory results, but I must advise all of my patients that I will **not** testify as an expert witness in any legal proceedings whether for a plaintiff's attorney or a defendant's attorney. My schedule is too demanding and it takes away from my focus of providing the best medical care possible.

Patient signature: _____

Health History

Patient Name: _____ Date: _____

Age: _____ Birthdate: ____/____/____ Height _____ Weight _____

What is the reason for your visit today? _____

Allergies: Are you allergic to any medications? ____ Yes ____ No

If yes, please list medication(s) and type of reaction(s): _____

Latex allergy: ____ Yes ____ No **Sensitivity to adhesive tape:** ____ Yes ____ No

Medications: ____ Yes ____ No If yes, please list all medications you are currently taking including herbal medicines, diet pills, vitamins, supplements and over-the-counter medications: _____

Hospitalizations and/or previous surgeries: ____ Yes ____ No If yes, please list with dates and hospital where surgery was performed: _____

Do you use tobacco or nicotine products: ____ Yes ____ No If yes, which product, how frequent and for how long have you used this product? _____

Have you or an immediate family member ever been diagnosed with a STAPH (MRSA) infection?

____ Yes ____ No If yes, who/when: _____

Are you currently under the care of a physician(s): ____ Yes ____ No If yes, please list name of physician(s), phone number(s) and what you are being treated for: _____

Who is your primary care physician/phone number? _____

Are you now or have you been under the care of a psychiatrist/therapist within the past 2 years:

____ Yes ____ No If yes, for what: _____

Cardiovascular: (any personal history of the following)

High Blood Pressure ____ Yes ____ No

Coronary Artery disease ____ Yes ____ No

Angina/chest pain ____ Yes ____ No

Prior heart attack ____ Yes ____ No

Heart valve disease ____ Yes ____ No

Heart rhythm problems
and/or pacemaker ____ Yes ____ No

Elevated cholesterol ____ Yes ____ No

DVT (Deep vein thrombosis) ____ Yes ____ No

Pulmonary Embolism ____ Yes ____ No

Mitral valve prolapse ____ Yes ____ No

Heart Murmur ____ Yes ____ No

Do you have a cardiologist? ____ Yes ____ No

If yes, who?/where? _____

Previous cardiac tests? (EKG, ECHO, stress test, etc.) ____ Yes ____ No

If yes, what/when? _____

Sickle Cell disease or trait? ____ Yes ____ No

Other heart disease: _____

Endocrine:

Diabetes Yes No
If yes, on insulin Yes No
Thyroid disease Yes No

Renal:

Kidney problems Yes No
Kidney stones Yes No
Dark or chocolate colored urine Yes No

Gastrointestinal:

Do you drink alcohol? Yes No

If yes, how much/how often: _____

History of Hepatitis/liver problems Yes No
History of Ulcers Yes No
History of Acid Reflux Yes No
History of Blood Transfusions Yes No
Hiatal Hernia Yes No
Mononucleosis in the past 6 months Yes No

Pulmonary:

Asthma Yes No

If yes, ever required any steroids? Yes No

COPD/ Bronchitis/ Emphysema Yes No
Sleep Apnea Yes No
Sleep Study performed Yes No
Do you use a CPAP device/mask? Yes No

When and where: _____

Name/number of treating doctor: _____

Recent respiratory illnesses Yes No
Difficulty climbing two flights of stairs Yes No

Neuro:

History of Loss of Consciousness Yes No
Stroke Yes No
Seizures Yes No
Peripheral Neuropathy Yes No
(numbness/weakness/shooting pains in limbs)
Back or neck trouble Yes No

Airway:

Caps/Crowns Yes No
Dentures or bridges Yes No
Loose or chipped teeth Yes No
TMJ syndrome Yes No
Neck/Cervical spine problems Yes No

History of previous difficult intubation Yes No

Has a dentist ever told you that you have difficult/limited access to your teeth due to your airway anatomy?
 Yes No

General:

Do you have any blood disorders _____ Yes _____ No
History of prolonged bleeding _____ Yes _____ No
Large scars or keloids _____ Yes _____ No
Skin Diseases _____ Yes _____ No
Cancer _____ Yes _____ No If yes, what type: _____

Any other illness not listed above?: _____

Anesthesia:

Any previous general anesthetic complications? _____ Yes _____ No
If yes, what was your reaction? _____

History of motion sickness? _____ Yes _____ No
Family members with anesthetic complications? _____ Yes _____ No
If yes, what was the reaction: _____

Family history of malignant hyperthermia _____ Yes _____ No
High fever following strenuous exercise _____ Yes _____ No

Family History: check (X) if blood relatives have had any of the following.:

Relationship to you

- Breast cancer _____
- Keloid scars _____
- Bleeding disorders _____
- Prolonged Bleeding _____
- DVT (Deep vein thrombosis) _____
- Other: _____
- Diabetes _____
- Heart disease/stroke _____
- PE (Pulmonary Embolism) _____

Please explain any yes answers here, if not already explained above:

Patient Signature Date: _____

Philip J. Straka, M.D. Date: _____

Anesthesiologist Date: _____