PATIENT INFORMATION

DATE:_____ SS#:_____

NAME:_____
LAST FIRST MIDDLE

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE_____

DOB:_____/_____/_____ AGE:_____ MARITAL STATUS: M S D W SEP

Primary contact #: ( )_____ Is this: Home Cell Work Other:_____
May we leave a detailed message at this number? Yes No

Secondary contact #: ( )_____ Is this: Home Cell Work Other:_____
May we leave a detailed message at this number? Yes No

Email address: _____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED:_____

PHONE:_____RELATIONSHIP:_____

PATIENT EMPLOYER INFORMATION

PATIENT EMPLOYED BY:_____

OCCUPATION:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

PHONE:_____ May we leave a detailed message at this number? Yes No

HOW DID YOU FIND OUT ABOUT US:

□ □Phone book □Previous Patient(please list below) □□Physician(please list below)

□ Google □ Yahoo □□loveyourlook.com

□Internet (other) _____(please list source)

PLEASE LIST REFERRAL NAME/LOCATION:_____

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.
- if there are financial matters in dispute after the fact, I waive my right to privacy under the HIPAA Act of 1996

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 When and where:_____
Do you use a CPAP device/mask? _____Yes _____No
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 _____ □ Diabetes _____
□ Bleeding disorders _____ □ Heart disease/stroke _____
□ Prolonged Bleeding _____ □ PE (Pulmonary Embolism)_____
□ DVT (Deep vein thrombosis) _____
□Other:_____

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

_____
_____
_____
_____
_____

_____ Date: _____
Patient Signature

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

_____ Date: _____
Anesthesiologist