NTSOA

Patient Forms

- 4001 W 15th Street, STE 425, Plano, TX 75093
- 5680 Frisco Square Blvd., STE 2500, Frisco, TX 75034
- 4510 Medical Center Drive, STE 302, McKinney, TX 75069
- 6750 N MacArthur Blvd., STE 257, Las Colinas, TX 75039
- 7777 Forest Lane, STE C-520, Dallas, TX 75230

Phone: (972) 696-0030 Fax: (972) 696-0037

Thomas E. Le Voyer, MD
M. Umar Butt, MD
Fred S. Lee, MD
Furrukh Jabbar, MD

Today's Date: ____________________ Name: ____ DOB: __________________

What is the reason for your visit today? ____

Current Medication	Dose	Directions	Reason

Allergic To	Reaction

SURGICAL HISTORY

Surgeries	Date of Surgery

PAST MEDICAL HISTORY (Please check all that apply)

- ☐ High blood pressure
- ☐ Heart attack
- ☐ High Cholesterol
- ☐ Irregular heart beat
- ☐ Kidney stones
- ☐ Kidney failure
- ☐ Recurrent urinary infections
- ☐ Hepatitis A, B, C
- ☐ Cirrhosis
- ☐ Headaches
- ☐ Neuropathy
- ☐ Parkinson's disease
- ☐ Dementia
- ☐ Alzheimer's
- ☐ Seizures
- ☐ Meningitis
- ☐ Multiple sclerosis
- ☐ Anemia
- ☐ Blood clots
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Pituitary disease
- ☐ Adrenal disease
- ☐ Emphysema
- ☐ Asthma
- ☐ Hay Fever
- ☐ COPD
- ☐ Tuberculosis
- ☐ Pulmonary embolus
- ☐ HIV/AIDS
- ☐ Lupus
- ☐ Rheumatoid arthritis
- ☐ Depression
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Stomach ulcers
- ☐ Crohn's disease
- ☐ Ulcerative Colitis
- ☐ Diverticulosis
- ☐ Irritable bowel syndrome
- ☐ Gallstones
- ☐ Pancreatitis
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Gout
- ☐ Eczema
- ☐ Psoriasis
- ☐ Lipoma
- ☐ Shingles
- ☐ Gastroesophageal reflux disease (GERD)
- ☐ Insomnia

Other Significant Past Medical History:

☐ ______________________________

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PERSONAL/FAMILY HISTORY

	You	Father's Side		Mother's Side		Sibling/Children	
Age of Diagnosis →	**Age**	**Age**	**Living?**	**Age**	**Living?**	**Age**	**Living?**
Example: Colon Cancer		**Aunt at 44**	**Yes**	**Grandfather at 65**	**Yes**	**Brother at 36**	**Yes**
Heart Attack							
Diabetes							
Stroke							
High Blood Pressure							
Blood Clots							
Breast Cancer							
Ovarian Cancer							
Prostate Cancer							
Pancreatic Cancer							
Melanoma							
Uterine (endometrial) Cancer							
Colon Cancer							
Stomach, Kidney/urinary, brain, OR small bowel cancer							
10 or more colon polyps found in a life time							
Other type of cancer (please write in)							

Are you of Ashkenazi Jewish decent? **Y** **N**
Age of first period (if applicable) ______________
Age of First Child (if applicable) ______________
Are you Menopausal? Y N
Have you ever had hormone replacement therapy? Y N
If you answered yes to Breast Cancer:
Was Tamoxifen or Herceptin prescribed? Y N
Breast cancer in both breasts? Y N
Have you had a surgical or needle biopsy of the breast? Y N
If yes, did the biopsy show atypical cells? Y N
Has anyone in your family had genetic testing for a hereditary cancer syndrome?
Y **N**

OFFICE USE ONLY

Confirmed TRIPLE NEGATIVE STATUS Y N
Patient meets NCCN criteria for testing Y N
Doctor informed patient meets NCCN criteria for hereditary cancer testing? Y N

NTSOA staff initials: ____________

ALCOHOL, TOBACCO, CAFFEINE, AND DRUG USE

Present Use:			Type/Amount	Past Use:			Type/Date Stopped
Alcohol	Y	N	______________	Alcohol	Y	N	______________
Tobacco	Y	N	______________	Tobacco	Y	N	______________
Illegal Drugs	Y	N	______________	Illegal Drugs	Y	N	______________
Caffeine	Y	N	______________	Caffeine	Y	N	______________

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HEARTBURN & ACID REFLUX QUESTIONNAIRE

Are you taking medication for acid reflux?
Yes No Unknown
Names (e.g. Nexium, Prilosec, omeprazole, Tums, Zantac, Pepcid)
____
Dose and frequency
____

Do you have a gastroenterologist (GI doctor)?
Yes No Unknown
Name ____________________________

Do you have an Ear Nose &Throat doctor (ENT)?
Yes No Unknown
Name ____________________________

Have you ever had an upper endoscopy (EGD)?
Yes No Unknown
When? ____________________________

Have you ever had a barium swallow?
Yes No Unknown
When? ____________________________

Have you ever had acid reflux testing (pH test)?
Yes No Unknown
When? ____________________________

Have you ever had esophageal testing (manometry)?
Yes No Unknown
When? ____________________________

Do you have a hiatal hernia?
Yes No Unknown
Do you have Barrett's esophagus?
Yes No Unknown
Do you have a family history of esophageal cancer?
Yes No Unknown

Please circle the number that best reflects your symptoms using the scoring scale provided below.

Scoring Scale
0 = No symptoms
1 = Symptoms noticeable but not bothersome
2 = Symptoms noticeable and bothersome but not every day
3 = Symptoms bothersome every day
4 = Symptoms affect daily activities
5 = Symptoms are incapacitating – unable to do activities

1. How bad is your heartburn (if not taking medications)?	0	1	2	3	4	5
2. Heartburn when lying down (if not taking medications)?	0	1	2	3	4	5
3. Heartburn when standing up (if not taking medications)?	0	1	2	3	4	5
4. Heartburn after meals (if not taking medications)?	0	1	2	3	4	5
5. Does heartburn change your diet (if not taking medications)?	0	1	2	3	4	5
6. Does heartburn wake you from sleep (if not taking medications)?	0	1	2	3	4	5
7. Do you have difficulty swallowing (if not taking medications)?	0	1	2	3	4	5
8. Do you have bloating or gassy feelings (if not taking medications)?	0	1	2	3	4	5
9. Do you have pain with swallowing (if not taking medications)?	0	1	2	3	4	5
10. If you take medication, does this affect your daily life?	0	1	2	3	4	5

11. How satisfied are you with your present condition? Satisfied Neutral Dissatisfied

Within the past month, how did the following problems affect you? Please circle one number for each symptom.

	No Problem				**Severe Problem**	
1. Hoarseness or other voice problems	0	1	2	3	4	5
2. Clearing throat	0	1	2	3	4	5
3. Excess throat mucus or postnasal drip	0	1	2	3	4	5
4. Difficulty swallowing food, liquid, or pills	0	1	2	3	4	5
5. Coughing after eating	0	1	2	3	4	5
6. Breathing difficulties or choking episodes	0	1	2	3	4	5
7. Troublesome or annoying cough	0	1	2	3	4	5
8. Sensations of something sticking in throat or lump in throat	0	1	2	3	4	5
9. Heartburn, chest pain, indigestion or stomach acid coming up	0	1	2	3	4	5

OFFICE USE ONLY **NTSOA staff initials: ______________**

Patient is possible candidate for anti-reflux surgery?	Y	N
Patient would like to discuss reflux options with the physician	Y	N
Doctor informed patient is interested in Reflux consult?	Y	N

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REVIEW OF SYSTEMS

Please circle (Y) or (N) any of the following that apply to symptoms you are recently or currently experiencing. Address each section carefully.

General
Change in appetite Y N
Chills Y N
Fever Y N
Fatigue Y N
Weight gain Y N
Weight loss Y N
Pain Y N
Insomnia Y N
Other ____________________

Allergy/Immunology
Rash Y N
Wheezing Y N
Other ____________________

Ophthalmologic
Change in vision Y N
Discharge Y N
Other ____________________

ENT
Decreased hearing Y N
Nosebleeds Y N
Painful swallowing Y N
Earaches Y N
Hoarseness Y N
Mass or lumps Y N
Other ____________________

Endocrine
Cold intolerance Y N
Heat intolerance Y N
Excessive thirst Y N
Excessive sweating Y N
Other ____________________

Respiratory
Cough Y N
Shortness of breath at rest Y N
Shortness of breath with exertion Y N
Wheezing Y N
Other ____________________

Cardiovascular
Chest pain at rest Y N
Chest pain with exertion Y N
Difficulty lying flat Y N
Irregular heartbeat Y N
Other ____________________

Gastrointestinal
Abdominal Pain Y N
Blood in stool Y N
Change in bowel habits Y N
Difficulty swallowing Y N
Heartburn Y N
Reflux Y N
Nausea Y N
Rectal bleeding Y N
Vomiting Y N
Constipation Y N
Diarrhea Y N
Other ____________________

Hematology
Easy bruising Y N
Easy bleeding Y N
Other ____________________

Genitourinary
Difficulty urinating Y N
Urinary frequency Y N
Painful urination Y N
Other ____________________

Musculoskeletal
Joint stiffness Y N
Painful joints Y N
Swollen joints Y N
Other ____________________

Peripheral Vascular
Cold extremities Y N
Decreased sensation in extremities Y N
Other ____________________

Skin
Mole(s) Y N
Nodule(s) Y N
Rash Y N
Skin Cancer Y N
Other ____________________

Neurological
Trouble with balance Y N
Gait abnormality Y N
Headache Y N
Seizures Y N
Numbness/Tingling Y N
Dizziness Y N
Lightheadedness Y N
Memory Changes Y N
Other ____________________

Psychological
Anxiety Y N
Depressed mood Y N
Difficulty sleeping Y N
Other ____________________

Cancer Related
Chemotherapy Y N
Radiation Y N