



PCA – Primary Care Associates
 4211 Joe Ramsey Blvd, Ste 100
 Greenville TX 75401

SURGICAL DATABASE

JOSHUA K. TRUSSELL, M.D.
 REBECCA JANKOWSKI, M.D.
 GENERAL SURGEON

NAME: _____ **DOB:** _____

MEDICATION ALLERGIES: _____

PAST SURGERIES AND DATES:

APPENDECTOMY _____	CHOLECYSTOMY _____
C-SECTION _____	CATARACT _____
HERNIA _____	TONSILLECTOMY _____
HYSTERECTOMY _____	
OTHER (please list all): _____	

OF PREGNANCIES: _____
 Live Births _____ Miscariages _____ Abortions _____ C-Section _____

PAST MEDICAL HISTORY (Please circle yes or no and explain below):

Asthma:	Yes	No	Hypertension:	Yes	No
Chronic Bronchitis:	Yes	No	Hepatitis:	Yes	No
Emphysema:	Yes	No	Kidney Disease:	Yes	No
Cancer:	Yes	No	Bloodborne Path:	Yes	No
Diabetes (Insulin):	Yes	No	Pneumonia:	Yes	No
Diabetes (Non Insulin):	Yes	No	Recent:	Yes	No
Heart Attack (in last 6 mths):	Yes	No	Rheumatic Fever:	Yes	No
Seizures:	Yes	No	Tuberculosis:	Yes	No
Angina:	Yes	No	Congestive Heart Failure:	Yes	No
Palpitations:	Yes	No	Chest Pain:	Yes	No
Sleep Apnea:	Yes	No	Cough:	Yes	No
Shortness of Breath:	Yes	No		Yes	No

Please explain ALL YES answers:

Have you ever had any complications with surgery?

Have you ever had any problems with bleeding?

SOCIAL HISTORY

Marital Status: Single Married Divorced Widowed
Do you drink Alcohol? No Yes If yes how often? _____
Do You Smoke? No Yes How many packs per day? _____ How many years? _____
If Quit, when? _____
Have you ever used Illegal Drugs? _____ Have you ever used IV Drugs? _____
Have you ever received a blood transfusion or blood product? Yes No
- If yes, when? _____

FAMILY HISTORY

	Living Age:	Deceased Age:	List all illnesses:
Mother:	_____	_____	_____
Father:	_____	_____	_____
Brothers:	_____	_____	_____
Sisters:	_____	_____	_____

GIVE THE DATE OF YOUR LAST:

Mammogram:	_____	Colonoscopy:	_____
Tetanus shot:	_____	Physical Exam:	_____

PLEASE LIST ALL MEDICATIONS AND HOW YOU TAKE THEM:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

By signing below the patient acknowledges all information above is correct.

X

(PATIENT OR REPRESENTATIVE SIGNATURE)

(DATE)

(RELATIONSHIP IF OTHER THAN PATIENT)

Circle Any Problems Below

Constitutional: Weight change, fevers, sweats or chills.

HEENT: Significant allergies, sore throats, change in vision, change in hearing, food sticking in throat, pain with swallowing, or yellow eye color.

Respiratory: Shortness of breath, painful breathing on exertion or unusual/persistent cough.

Cardiovascular: Chest pain (if so, exertional or at rest), congestive heart failure symptoms, palpitations or severe calf pain with walking (if so, at what distance).

Gastrointestinal: Nausea, vomiting, diarrhea, constipation, change in bowel movements, blood per rectum or dark tarry stool.

G: Pain with urination, blood in urine, incontinence or difficulty voiding.

Musculoskeletal: Unusual joint pain, immobility or loss of function.

Neurologic: Headaches, dizziness, localized weakness, neuropathy, loss of sensation/function.

Skin: Rash, hives, easy bruisability, masses, jaundice (yellow skin) or skin lesions.

Endocrine: Unusual weight loss/gain, excessive urination, excessive thirst, hair loss/gain.

Psychiatric: Feelings of anxiety, depression, mood swings or sleep disturbance.

Physical exercise: (Describe exercise tolerance)

Patient Name

Date of Birth

Patient/Guardian Signature

Date



Insurance Information

Patient Name	Date of Birth
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Primary Insurance

Policy Holder Name:		<input type="checkbox"/> Male <input type="checkbox"/> Female	Name of Insurance Co.
Date of Birth:	Social Security Number:	Relationship to Patient:	
Employer			
Other members covered on policy:			
Name:	Date of Birth:	Relationship:	
Name:	Date of Birth:	Relationship:	
Name:	Date of Birth:	Relationship:	
Name:	Date of Birth:	Relationship:	

Secondary Insurance:

Policy Holder Name:		<input type="checkbox"/> Male <input type="checkbox"/> Female	Name of Insurance Co.
Date of Birth:	Social Security Number:	Relationship to Patient:	
Employer			
Other members covered on policy:			
Name:	Date of Birth:	Relationship:	
Name:	Date of Birth:	Relationship:	
Name:	Date of Birth:	Relationship:	

Guarantor (person responsible for payment)

Name	Relationship to patient	Date of Birth	Social Security Number
Address of Guarantor if different than Patient:			

X _____

Patient OR Responsible Party

Relationship

Date



ADULT HIPAA / RELEASE OF INFORMATION PER PATIENT'S ASSIGNMENT

I have acknowledged/received a written copy of PCA's "Notice of Privacy Practices".

Patient's name _____ DOB ____ / ____ / ____

I hereby give permission to Primary Care Associates to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s), and/or close personal friend(s):

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

OR

_____ Initial here if you **DO NOT** authorize assignment of any person(s) to communicate with PCA-Primary Care Associates, P.A, for any reason, including your emergency contact.

 **I WISH TO BE CONTACTED IN THE FOLLOWING MANNER:**

HOME #: _____	CELL #: _____	WORK #: _____
Ok to leave a message? YES	Ok to leave a message? YES	Ok to leave a message? YES
NO	NO	NO

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that request for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

Patient / Representative: **X** _____ Date _____

Relationship (if other than patient) _____

A COPY OF THIS DOCUMENT IS VALID AS AN ORIGINAL