BAYLOR SCOTT & WHITE MEDICAL CENTER – GRAPEVINE
PATIENT HEALTH INFORMATION REQUEST FORM

At which of the following number(s) do we have permission to contact you?

☐ Home _____ May we leave a message for you at home?
☐ Cell _____ ☐ Yes ☐ No
☐ Work _____ May we leave a message for you at work?
☐ Other _____ ☐ Yes ☐ No

Preferred Pharmacy _____
Address _____
Phone Number _____

Please provide your email address for "Follow My Health" invitation

Email address: _____

Other than you, whom may we talk to about your healthcare information?

☐ Spouse Name/Telephone _____
☐ Caretaker Name/Telephone _____
☐ Child Name/Telephone _____
☐ Parent Name/Telephone _____
☐ Other Name/Telephone _____

*Please indicate phone number where an approved contact may be reached during surgery

_____

Do you have any health information that you would like kept confidential from any person or persons?

☐ Yes ☐ No

If so, please describe below:

_____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

_____ _____
Patient or Personal Representative Signature Date Time

_____ _____
Printed Name Relationship to Patient

MED REC NO. _____
PATIENT _____
PHYSICIAN _____
BILLING NO. _____

PRE ADMIT TESTING ANESTHESIA QUESTIONNAIRE

	Yes	No	Questions to be completed by Patient or Representative (Please answer Yes or No, and check all that apply)
1	☐	☐	**Any previous problems or adverse reactions to anesthesia?**
2	☐	☐	**Have you or any of your blood relatives have problems with malignant hyperthermia or high fevers with anesthesia?**
3	☐	☐	**Do you have problems opening your jaw?**
4	☐	☐	**Were you ever told it was difficult to insert the breathing tube?** **Explain** _____
5	☐	☐	Do you have epilepsy or suffer from fits or seizures? Last occurrence? _____ /_____
6	☐	☐	**Have you had a ☐ stroke ☐ partial stroke ☐ transient ischemic attack? When?** _____ /_____ **Any remaining effects?** _____
7	☐	☐	Do you have problems with your heart or blood vessels?
8	☐	☐	**Do you have any known blockages of the heart blood supply that have not been corrected by treatment?**
9	☐	☐	Have you had a heart attack greater than 2 years ago? When? _____ /_____
10	☐	☐	**Have you had a previous heart attack within the last 2 years?**
11	☐	☐	Have you ever been hospitalized for any of your heart problems?
12	☐	☐	**Have you had heart bypass surgery within the last 2 years?**
13	☐	☐	**Have you had stents placed in your heart within the last 12 months?**
14	☐	☐	Do you get short of breath when climbing up a flight of stairs?
15	☐	☐	**Do you currently have chest pain that has not been evaluated by a physician?**
16	☐	☐	**Have you ever had any heart rhythm problems such as ☐ Atrial fibrillation ☐ Atrial flutter,** **☐ Paroxysmal Supraventricular Tachycardia (PSVT)** **☐ Palpitations with symptoms (dizziness, shortness of breath)? When?** _____ /_____

Patient/Legal Guardian Signature _____ **Date** _____ **Time** _____

(Patient Label)

BAYLOR REGIONAL MEDICAL CENTER
GRAPEVINE, TEXAS

PRE ADMIT TESTING ANESTHESIA QUESTIONNAIRE

34	☐	☐	Do you have any blood infections such as ☐ Human Immunodeficiency Virus (HIV) or ☐ Hepatitis B ☐ Hepatitis C? ☐ Recent exposure?
35	☐	☐	**Have you had liver disease? ☐ Cirrhosis, ☐ Hepatitis, ☐ Jaundice, ☐ Alcoholism or ☐ Ascites?**
36	☐	☐	Do you have frequent ☐ Heartburn ☐ Indigestion ☐ Acid ruflex from your stomach ☐ Hiatal hernia?
37	☐	☐	**Have you had kidney disease? ☐ Insufficiency, ☐ Failure, or ☐ Kidney removal**
38	☐	☐	Do you have problems with your thyroid gland? ☐ Over Active ☐ Under active?
39	☐	☐	Do you have false teeth or oral jewelry? Details _____
40	☐	☐	Do you have neck or back problems? ☐ Arthritis ☐ Herniated disc ☐ Neck pain ☐ Arm pain ☐ Numbness
41	☐	☐	Do you have any other health problems not already discussed? Explain _____
42	☐	☐	Have you had sleep apnea surgery?
43	☐	☐	Do you snore most nights? ☐ It is loud ☐ I have been told I stop breathing or gasp during sleep
44	☐	☐	Do you occasionally doze or fall asleep during the day when you are not busy or active?
			FOR FEMALES ONLY
45	☐	☐	**Women's Health History: ☐ Pregnant ☐ Menstruating ☐ Menopausal ☐ Prior Procedure / Unknown**
46	☐	☐	**Date of your last menstrual period _____ / _____**
47	☐	☐	Prior procedure such as ☐ Tubal Ligation, ☐ Tube Occlusion, ☐ Endo Ablation, ☐ Hysterectomy?
48	☐	☐	Would you like to be tested for possible pregnancy? ☐ Yes ☐ No

Patient/Legal Guardian Signature **Date** **Time**

(Patient Label)

BAYLOR REGIONAL MEDICAL CENTER
GRAPEVINE, TEXAS

PRE ADMIT TESTING ANESTHESIA QUESTIONNAIRE

17	☐	☐	**Have you ever had Congestive Heart Failure?**
18	☐	☐	**Have you had an increase in severity or frequency of ☐ exercise intolerance, ☐ chest pain ☐ shortness of breath over the past several months?**
19	☐	☐	***Do you have ☐ pacemaker or ☐ Implantable Cardioverter Defibrillator (ICD)?***
20	☐	☐	**Has it been more than 12 months since your heart pacemaker or Implantable Cardioverter Defibrillator (ICD) has been checked?**
21	☐	☐	Have you ever been told you have high blood pressure not associated with pregnancy? How Long? _____ months _____ years
22	☐	☐	**Do you have emphysema or chronic obstructive pulmonary disease (COPD) that requires oxygen at home?**
23	☐	☐	Do you have ☐ chronic bronchitis or ☐ asthma ☐ Wheezing this week?
24	☐	☐	Have you ever been hospitalized for emphysema or asthma? When? _____ /_____
25	☐	☐	**Do you have a cough that has gotten worse recently? Do you cough up blood?**
26	☐	☐	Do/have you ☐ currently smoke ☐ smoked in the past? Number of packs per day? _____ How many years? _____ When quit? _____ /_____
27	☐	☐	Have you had any ☐ fever, ☐ chills, ☐ cold, or ☐ flu within the last several weeks?
28	☐	☐	**Have you been told you have sugar diabetes (Not during Pregnancy) ☐ Type 1 ☐ Type 2** **How Long? _____ months _____ years**
29	☐	☐	Have you done any recreational drugs recently? What?_____ When? _____ When last time? _____ /_____
30	☐	☐	**Have you had anemia?**
31	☐	☐	Other problems with your blood (leukemia, sickle cell)? Explain _____
32	☐	☐	**Do you have a bleeding disorder or bruises that appear without cause?** **Explain** _____
33	☐	☐	Have you ever had a blood transfusion? When? _____ /_____

_____ _____ _____

Patient/Legal Guardian Signature **Date** **Time**

(Patient Label)

BAYLOR REGIONAL MEDICAL CENTER
GRAPEVINE, TEXAS

Primary Care Doctor	_____	Phone # _____
Cardiologist	_____	Phone # _____
Other. _____	_____	Phone # _____

Medication Allergies

	Medication	Describe Reaction
☐ None	_____	_____
	_____	_____
	_____	_____
	_____	_____

Past Surgeries	Date	Location / Facility
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

	Date	Location / Facility / Phone
Prior EKG	_____	_____
Prior Heart Studies, Stress Tests, etc	_____	_____

_____ _____ _____

Patient / Legal Guardian Signature **Date** **Time**

(Patient Label)

BAYLOR REGIONAL MEDICAL CENTER
GRAPEVINE, TEXAS

BAYLOR REGIONAL MEDICAL CENTER AT GRAPEVINE
PATIENT MEDICATION LIST

If you have brought a list of medications from home, please turn in your list and do not fill out this form. If you do not have a medication list with you, please fill out the information below including all prescription and non-prescription (over the counter) medications Please include all inhalers, supplements, eye drops, vitamins and herbals

	Medication Name	**Dose** (How many mg)	**Route** (How you take)	**Frequency** (How often do you take this?)
1				
2				
3.				
4				
5.				
6				
7				
8				
9				
10.				
11				
12				
13				
14.				
15				

BAYLOR REGIONAL MEDICAL CENTER AT GRAPEVINE

Not Part of the Permanent Medical Record

Get Your Prescriptions Filled Before You Leave

Baylor Scott & White Pharmacy (#107) at Grapevine
817-388-3090
Mon- Fri 7:00-7:00, Sat 9:00-1:00

Being in the hospital can be a stressful time, not only for the patient, but for the family, friends and caregivers involved. When the day comes to go home, you start to realize all the things you have to coordinate. A lot of times the family will try to get the patient home and settled and then go to the pharmacy to get the prescriptions. This means they may be left alone, and it's more time for a pain medication to wear off before they get the new prescription home. It's chaotic, and still stressful. That's why we are hoping we can help. **We are the Outpatient pharmacy at Baylor Scott & White Medical Center – Grapevine**. We are just like any other retail pharmacy, just a lot closer! We're in the professional office building on the first floor, right in front of the elevators.

Should you choose to use us, your nurse can fax us your prescriptions and pharmacy insurance information ahead of time. Then we can bill your prescriptions just like any other pharmacy.

Once the prescriptions are ready you or a family member/friend can come pick them up at your convenience or we can bill your credit card and **deliver them to your room** before you leave. The choice is yours. There is no additional fee for this service. If you would like to speak to a pharmacist about your medications you can call the number on the label during business hours (M-F 7am-7pm, Sat 9am-1pm) or come to the pharmacy to pick them up.

This way when you get in the car to go home, you have everything you need. There are no more stops to make, until you hit the bed!

If Baylor Scott & White Pharmacy at Grapevine does not fill all of the prescriptions faxed to us at the time of discharge and you need them filled at another pharmacy at a later date, just give that pharmacy our phone number and all the information can be transferred over the phone when they call. The same procedure applies if you want to get your refills at another pharmacy.

If you have any questions about the service please feel free to call us. We'd be happy to help. We hope we can make the transition home, and your recovery, a little easier.

Sincerely,

Baylor Scott & White Pharmacy Staff