Baylor St. Luke's Medical Group

Baylor College of Medicine

Specialty appendices

Baylor St. Luke's Medical Group | Baylor College of Medicine

Urology Service Acknowledgement

We provide expert consultation for Urology services and perform related procedures for you and your referring health care provider. We do not provide primary care services for other medical problems. It is important for you to have a primary care provider.

We provide prescriptions for medications related to your procedure problems only. We do not renew prescriptions of other physicians.

We refill prescriptions by phone only during office hours. We cannot refill any

prescriptions on nights or weekends. Please allow 3-5 working days to process your request. You can greatly speed up refills if you have your pharmacy send an electronic refill request.

We do not evaluate for disability or complete disability paperwork.

____

Signature of Patient or Authorized Representative Date

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Print Name of Patient or Authorized Representative

International Prostate Symptom Score (IPSS)

Determine Your BPH Symptoms Circle your answers and add up your scores at the bottom.

Over the past month	Not at all	Less than one time in five	Less than half the time	About half the time	More than half the time	Almost always
Incomplete emptying- How often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Frequency- How often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Intermittency- How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
Urgency- How often have you found it difficult to postpone urination?	0	1	2	3	4	5
Weak stream- How often have you had a weak urinary stream?	0	1	2	3	4	5
Straining- How often have you had to push or strain to begin urination?	0	1	2	3	4	5
Sleeping- How many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	None 0	One Time 1	Two Times 2	Three Times 3	Four Times 4	Five or More Times 5
Add Symptom Scores:						

Total International Prostate Symptom Score = ______________________

1-7 mild symptoms 8-19 moderate symptoms 20-35 severe symptoms

Regardless of the score, if your symptoms are bothersome you should notify your doctor.

Quality of Life (QoL)	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Would you be interested in treatment options? YES NO

Sexual Health Inventory For Men (SHIM)

Instructions:
Each question has 5 possible responses. Circle the number that best describes your own situation. Select only 1 answer for each question.

Over the past 6 months:

1. How do you rate your confidence that you could keep an erection?

1	2	3	4	5
Very Low	Low	Moderate	High	Very High

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?

1	2	3	4	5
Almost never or never	A few times (Much less than half the time)	Sometimes (About half the time)	Most times (Much more than half the time)	Almost always

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?

1	2	3	4	5
Almost never or never	A few times (Much less than half the time)	Sometimes (About half the time)	Most times (Much more than half the time)	Almost always

4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?

1	2	3	4	5
Extremely difficult	Very difficult	Difficult	Slightly difficult	Not Difficult

5. When you attempted sexual intercourse, how often was it satisfactory for you?

1	2	3	4	5
Almost never or never	A few times (Much less than half the time)	Sometimes (About half the time)	Most times (Much more than half the time)	Almost always

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Colorectal Surgery Service Acknowledgement

We provide expert consultation for Colorectal Surgery services and perform related surgeries for you and your referring health care provider. We do not provide primary care services for other medical problems. It is important for you to have a primary care provider.

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____
Signature of Patient or Authorized Representative

____
Date

____
Print Name of Patient or Authorized Representative

Baylor St. Luke's Medical Group | Baylor College of Medicine

Gastrointestinal Medical History

Circle all that apply

Barrett's Esophagus	Pancreatic Disease	Diverticulitis	H. Pylori Infection	Colitis
Celiac Disease	Ulcerative Colitis	Esophageal Cancer	Heartburn / GERD	Colon Cancer
Cirrhosis	Crohn's Disease	Fatty Liver	Hepatitis A/B/C	Colon Polyps
Liver Disease	Difficulty Swallowing	Gastric Cancer	Irritable Bowel Syndrome	Stomach Ulcers

Circle previous surgeries

Appendectomy	Fundoplication	Heart valve surgery	Kidney surgery	Prostate surgery
Cardiac Ablation	Gallbladder	Heller myotomy	Liver surgery	Small bowel surgery
Colon Surgery	Gastric surgery	Hemorrhoid surgery	Lysis of adhesions	Weight loss surgery
C-Section	Heart stent	Hernia repair	Organ transplant	Other:
Defibrillator	Heart surgery	Kidney stones	Pacemaker	

What medical problems run in your family? (Please check all that apply. If yes, indicate relationship)

Medical Problem	No	Yes	If Yes, Who?
Colon Cancer Colon Polyps			
Stomach / Esophageal Cancer			
Small Bowel Cancer			
Gallbladder Disease			
Liver Disease			
Ulcerative Colitis / Crohn's			
Diabetes/			
Heart Disease			
High Cholesterol			
High Blood Pressure			
Other:			

Circle previous diagnostic tests

Bravo pH Probe	Esophageal Manometry	Liver biopsy	Small bowel capsule	ERCP
Colonoscopy - Date of last exam:		Upper Endoscopy - Date of last exam:		

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Gastroenterology

Reason for Office Visit: ____________________

Do you take aspirin or NSAIDs (ibuprofen, Mortin, Aleve, Excedrin, BC Powders, Goodies)? ____________________

Have you received the Hepatitis A or Hepatitis B vaccination? ____________________

Do you have any metal in your body? ____________________

Have you had any previous problems with anesthesia or procedures? ____________________

Do you take any blood thinners? ____________________

If yes, who wrote or is managing the prescription? ____________________

Who referred you to ses gastroenterology? ____________________

OFFICE USE ONLY						
EGD	COLONOSCOPY	LABS	RADIOLOGY	GOLYTELY	CLENPIQ	OTHER PREP:
LOCATION: **SWV** **SLHW** **EITHER**						
ANTICOAGULATION / CARDIAC CLEARANCE:						
RED RECORDS:		SAMPLES:				
FOLLOW-UP	**DAY(S)**	**WEEK(S)**	**MONTH(S)**	**YEAR(S)**	**PRN**	

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Gastroenterology Service Acknowledgement

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______________________________________ ________________

Signature of Patient or Authorized Representative | Date

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Print Name of Patient or Authorized Representative

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Gastrointestinal Medical History

Circle all that apply

Barrett's Esophagus	Pancreatic Disease	Diverticulitis	H. Pylori Infection	Colitis
Celiac Disease	Ulcerative Colitis	Esophageal Cancer	Heartburn / GERD	Colon Cancer
Cirrhosis	Crohn's Disease	Fatty Liver	Hepatitis A/B/C	Colon Polyps
Liver Disease	Difficulty Swallowing	Gastric Cancer	Irritable Bowel Syndrome	Stomach Ulcers

Circle previous surgeries

Appendectomy	Fundoplication	Heart valve surgery	Kidney surgery	Prostate surgery
Cardiac Ablation	Gallbladder	Heller myotomy	Liver surgery	Small bowel surgery
Colon Surgery	Gastric surgery	Hemorrhoid surgery	Lysis of adhesions	Weight loss surgery
C-Section	Heart stent	Hernia repair	Organ transplant	Other:
Defibrillator	Heart surgery	Kidney stones	Pacemaker	

What medical problems run in your family? (Please check all that apply. If yes, indicate relationship)

Medical Problem	No	Yes	If Yes, Who?
Colon Cancer Colon Polyps			
Stomach / Esophageal Cancer			
Small Bowel Cancer			
Gallbladder Disease			
Liver Disease			
Ulcerative Colitis / Crohn's			
Diabetes			
Heart Disease			
High Cholesterol			
High Blood Pressure			
Other:			

Circle previous diagnostic tests

Bravo pH Probe	Esophageal Manometry	Liver biopsy	Small bowel capsule	ERCP
Colonoscopy - Date of last exam:		Upper Endoscopy - Date of last exam:		

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Heartburn & Acid Reflux Patient Intake Form

Name ______________________ Date ______________

Have You:

Used PPI/H2 for more than 6 months at any time?	☐ Yes	☐ No
Seen a Gastroenterologist for your reflux? If so, who:	☐ Yes	☐ No
Had an Endoscopy? If so, please provide date:	☐ Yes	☐ No
Been diagnosed with Barrett's Esophagus?	☐ Yes	☐ No
Had a pH study? If so, please provide date:	☐ Yes	☐ No
Done Manometry testing? If so, please provide date:	☐ Yes	☐ No
Had surgery for Reflux (GERD) or a Hiatal Hernia repair?	☐ Yes	☐ No
Had LPR Symptoms?	☐ Yes	☐ No

(Excessive throat clearing/Persistent cough/Hoarseness/ "Lump" in throat/ Postnasal drip/Excess throat mucus/ Trouble swallowing/Trouble breathing/Sore throat)

Are You Taking Any Of The Following Ppis?	**How Many Times/Day?**	
Prilosec® (Omeprazole)	☐ Once	☐ Twice
Nexium® (Esomeprazole)	☐ Once	☐ Twice
Prevacid® (Lansoprazole)	☐ Once	☐ Twice
Dexilant® (Dexlansoprazole)	☐ Once	☐ Twice
Protonix® (Pantoprazole)	☐ Once	☐ Twice
Aciphex® (Rabeprazole)	☐ Once	☐ Twice
Zegerid® (Omeprazole/Sodium Bicarb)	☐ Once	☐ Twice

Are You Taking Any Of The Following H2 Blockers?	**How Many Times/Day?**	
Pepcid® (Famotidine)	☐ Once	☐ Twice
Zantac® (Ranitidine)	☐ Once	☐ Twice
Tagamet® (Cimetidine)	☐ Once	☐ Twice
Axid® (Nizatidine)	☐ Once	☐ Twice

OFFICE USE ONLY BELOW:	
GERD-HRQL TOTAL SCORE:	RSI TOTAL SCORE:
Satisfied / Dissatisfied / Neutral	TAKING MEDS: YES NO
Patient requires testing (circle): EGD pH Bravo Manometry	
Other/Notes:	

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Heartburn & Acid Reflux Patient Intake Form

We may ask you to complete this form during every appointment to monitor the progression of your symptoms

______________________________ Name

__________ Date

The following are validated questionnaires to determine the severity of your symptoms. Please circle the answer that best describes your experience when you are NOT on medication.

Scoring Scale

0	1	2	3	4	5
No symptoms	Symptoms noticeable, but not bothersome	Symptoms noticeable & bothersome, but not every day	Symptoms bothersome every day	Symptoms affect daily activities	Symptoms are incapacitating, unable to do daily activities

GERD-HRQL (Measures Typical Symptoms)

Question						
1) How bad is your heartburn?	0	1	2	3	4	5
2) Heartburn when lying down?	0	1	2	3	4	5
3) Heartburn when standing up?	0	1	2	3	4	5
4) Heartburn after meals?	0	1	2	3	4	5
5) Does heartburn change your diet?	0	1	2	3	4	5
6) Does heartburn wake you from sleep?	0	1	2	3	4	5
7) Do you have difficulty swallowing?	0	1	2	3	4	5
8) Do you have pain with swallowing?	0	1	2	3	4	5
9) If you take medication, does this affect your daily life?	0	1	2	3	4	5
10) How bad is your regurgitation?	0	1	2	3	4	5
11) Regurgitation when lying down?	0	1	2	3	4	5
12) Regurgitation when standing up?	0	1	2	3	4	5
13) Regurgitation after meals?	0	1	2	3	4	5
14) Does regurgitation change your diet?	0	1	2	3	4	5
15) Does regurgitation wake you from sleep?	0	1	2	3	4	5
16) How satisfied are you with your present condition?	Satisfied		Neutral		Dissatisfied	

GERD-HRQL TOTAL SCORE: ____________________

Reflux Symptom Index (Measures Atypical Symptoms)

Question						
1) Hoarseness or a problem with your voice?	0	1	2	3	4	5
2) Clearing your throat?	0	1	2	3	4	5
3) Excess throat mucus or postnasal drip?	0	1	2	3	4	5
4) Difficulty swallowing food, liquids, or pills?	0	1	2	3	4	5
5) Coughing after you ate or lie down?	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 your throat or lump in your throat?	0	1	2	3	4	5
9) Heartburn, chest pain, indigestion, or stomach acid coming up?	0	1	2	3	4	5

RSI TOTAL SCORE: ____________________

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General Surgery

Reason for Office Visit: ____________________

Do you take aspirin or NSAIDs (ibuprofen, Mortin, Aleve, Excedrin, BC Powders, Goodies)? ____________________

Have you received the Hepatitis A or Hepatitis B vaccination? ____________________

Do you have any metal in your body? ____________________

Have you had any previous problems with anesthesia or procedures? ____________________

Do you take any blood thinners? ____________________

If yes, who wrote or is managing the prescription? ____________________

Who referred you to ses general surgery? ____________________

Are you currently having any of the following symptoms? (Please circle all that apply)

Constitution: fever, chills, weight loss, fatigue, weakness

Skin: rash, itching

Ears, Nose, Mouth, Throat: headaches, hearing loss, ringing in ears, ear pain, ear discharge, nosebleeds, congestion, sore throat

Eyes: blurred vision, double vision, eye pain, eye discharge, eye redness

Cardiovascular: chest pain, palpitations, leg swelling, leg pain with walking

Respiratory: cough, coughing blood, shortness of breath, wheezing

Gastrointestinal: frequent or painful urination, blood in urine

Musculoskeletal: muscle pain, neck pain, back pain, joint pain, falls

Endocrine: easy bruising or bleeding, allergies, excessive urination

Neurological: dizziness, tingling, tremor, speech change, weakness or numbness on one side, seizures, fainting or passing out

Psychiatric: depression, nervous/anxious, insomnia, memory loss, suicidal thoughts

OFFICE USE ONLY						
LABS	RADIOLOGY	MED RECORDS	EGD	COLONOSCOPY	GOLYTELY	PREPOPIK
SAMPLES:						
FOLLOW-UP	DAY(S)	WEEK(S)	MONTH(S)	YEAR(S)	PRN	

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General Surgery Service Acknowledgement

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ORTHOPEDICS

Reason for Office Visit: ______________________________

Which bone/joint is the problem: LEFT / RIGHT / BOTH ______________________________

How did this problem start? ☐ Accident ☐ Work-Related Injury ☐ Sports Injury ☐ No Injury/Unknown

Describe how this problem/injury/accident occurred: ______________________________

How long ago did the problem start? _____ Days _____ Weeks _____ Months _____ Years

How severe is your pain? (10 being the worst) 0 1 2 3 4 5 6 7 8 9 10

Describe radiation: ☐ None ☐ Numbness ☐ Tingling ☐ Weakness ☐ Where does it radiate? ______________

What is the quality of your pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching

What are your symptoms? ☐ Weakness ☐ Swelling ☐ Catching ☐ Popping ☐ Locking ☐ Grinding ☐ Shooting ☐ Numbness ☐ Tingling

Is your pain: ☐ Constant ☐ Intermittent (comes & goes)

Aggravating Factors (check all that apply)
☐ Standing ☐ Walking ☐ Lifting ☐ Exercise ☐ Twisting ☐ Bending ☐ Lying in bed ☐ Squatting
☐ Kneeling ☐ Stairs ☐ Sitting ☐ Typing

Alleviating Factors (check all that apply)
☐ Rest ☐ Elevation ☐ Ice ☐ Heat ☐ Compression/Brace ☐ NSAIDS ☐ Topical Creams ☐ Other__________

Ambulation Status (check all that apply)
☐ None ☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair ☐ Scooter ☐ Full Weight Bearing ☐ Partial Weight Bearing

Prior Treatments

Have you seen another provider for this problem? ☐ Yes ☐ No If yes, who: ______________________________

Medications: ☐ NSAIDS ☐ Tramadol ☐ Medrol Pack ☐ Tylenol #3 ☐ Gabapentin ☐ Norco ☐ Other ______________

Cortisone InjectionsL Celestone / Depo Medrol / Kenalog / Beta Date last given: ______________________________

Viscosupplementation Injections: ______________________________ Date last given: ______________

Physical Therapy: ☐ PT ☐ OT ☐ Home Health If Yes, where:______________________________

Have you had surgery for this problem? ☐ Yes ☐ No If yes, what kind ______________________________

Who performed the surgery? ______________________________ Date of surgery?______________

Fall Risk Status

Are you taking medication that affects your balance? ☐ Yes ☐ No

Do you have a history of falls? ☐ Yes ☐ No

Do you take precautions to prevent falls? ☐ Yes ☐ No

Have you fallen in the past 6 months? ☐ Yes ☐ No