



## ATX Robotic Surgery

Dr Shey Ditto  
11615 Angus Rd., Ste 106  
Austin, Tx 78759

Dr Sudeep Burman  
11615 Angus Rd., Ste 106  
Austin, Tx 78759

Dr Ronald Buczek  
11615 Angus Rd., Ste 106  
Austin, Tx 78759

Dr Adriana Castro  
11615 Angus Rd., Ste 106  
Austin, Tx 78759

PH: (512) 436-9986 FX: (512) 436-8295

### Pharmacy and Primary Care Provider

#### Pharmacy:

Preferred Pharmacy Name: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

Pharmacy Number: \_\_\_\_\_

#### Primary Care Physician:

Primary Care Physician: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

**If no PCP would you like to be referred to a PCP?**

Patient Declined PCP Referral

Send New Patient Referral Out



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**MEDICATION LIST**

Currently on blood thinners? YES or NO

Medication Name:

Are you currently taking a compound semaglutide injection?

If yes, when was your last injection?

Are you on Ozempic, Mounjaro, Wegovy, Trizepitide, Zepbound, Trulicity?

Medication Name: (name, dose, how often)	Medication Name: (name, dose, how often)

**Below List any Medications Allergic to**

Medication	Reaction/Level of Severity



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## MEDICAL HISTORY

Have you had or have you ever been diagnosed with any of the following:

<input type="checkbox"/> Anemia	<input type="checkbox"/> GERD	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Angina	<input type="checkbox"/> Goiter	<input type="checkbox"/> Stroke
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Migraine	<input type="checkbox"/> Stomach or Peptic ulcer
<input type="checkbox"/> Arthritis Type:	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer Type:	<input type="checkbox"/> High Blood Pressure	Other Medical Conditions Below
<input type="checkbox"/> Cataracts	<input type="checkbox"/> High Cholesterol	
<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> HIV/AIDS	
<input type="checkbox"/> Colitis	<input type="checkbox"/> Jaundice	
<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Depression	<input type="checkbox"/> Kidney Stones	
<input type="checkbox"/> Diabetes Type:	<input type="checkbox"/> Liver Disease (type)	
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Pneumonia	
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Psoriasis	
<input type="checkbox"/> Gallstones	<input type="checkbox"/> Pulmonary Embolism	

**Any Implantable Devices:** \_\_\_\_\_