CT Woolley, MD Medical Intake Form

Name_____
Height_____ Weight_____ (lbs / Kg)
Referring Provider _____
Provider's Phone/FAX( )_____ _,_____
Are you (*Right Handed*) or (*Left Handed*) ?

Have You Had: Circle Answer

Surgery or Anesthesia Before? *Yes No*
List Surgeries_____
_____
_____

Bad Reactions to Anesthesia *Yes No*
Relatives with Life Threatening Reaction to Anesthesia (eg: Malignant Hyperthermia) *Yes No*
High Blood Pressure *Yes No*
Heart Problems (Abnormal Rhythm or EKG) *Yes No*
Do you have any Implanted Electronic Devices such as a Pacemaker? *Yes No*
Do you have a Cardiac Stent? *Yes No*
If Yes: Type_____ When_____
Cardiologist's Name_____
Breathing Problems (Asthma, Emphysema, Abnormal Chest X-ray, Heavy Snoring) *Yes No*
If Yes, Have you had a Sleep Study? *Yes No*
What was the AHI_____
Recent Cold, Flu, or Communicable Disease? (Circle all that apply) *Yes No*
Liver Problems (Jaundice, Hepatitis) *Yes No*
Bleeding Problems *Yes No*
History of Anemia *Yes No*
Kidney Problems *Yes No*
Stomach or Intestinal Problems (Heartburn, Reflux, Ulcers, Hiatal Hernia) *Yes No*
Diabetes *Yes No*
If *Yes* Insulin [ ] Diet [ ] Oral Agent [ ]
Neurological Problems (Seizure, Stroke, Numbness, Weakness) *Yes No*
Neck, or Jaw Problems *Yes No*
Back Problems *Yes No*
Joint Problems or Artificial Joints *Yes No*
Cancer or Chemotherapy *Yes No*

Appointment Date_____
Current Problem_____
Location_____
Date of Birth ___/___/_____Age_____

My Contact Details_____
Home Phone ( )_____/_____
Cell Phone ( )_____/_____
Email_____
Preferred Language _____

Race_____
___ American Indian or Alaska native
___ Asian ___ Black or African American
___ Native Hawaiian or Pacific Islander
___ White ___ Decline to Answer

Ethnicity_____
___ Hispanic or Latino
___ Not Hispanic or Latino ___ Decline

Medications_____
_____
_____
_____

Do You: Circle Answer

Smoke or Use Tobacco *Yes No*
Packs/Cans per Day _____ Years _____
Have Allergies to Medicines, Latex, Tape Eggs or Iodine? *Yes No (list)*
_____
_____
_____
_____
Drink Alcohol *Yes No* , Drinks/wk_____
Use Recreational Drugs *Yes No*
Wear Contact Lenses *Yes No*
Have Loose / Removable Teeth *Yes No*
Female: Are you Pregnant or Nursing? *Yes No*

Pregnancy: Anesthesia and surgery carry an unknown risk to an early pregnancy. If there is any chance you are pregnant, the Anesthesiology department recommends that you obtain a pregnancy test within 48 hours of your elective procedure. You may decline this test
Would you like this test? *Yes No*

Other Medcial Problems, Illnesses, Injuries? Explanation / Comment : _____
_____
_____
_____

Signature_____ **Date _____ / _____ / _____**