Weill Cornell Medicine

Division of Endocrine &Minimally Invasive Surgery

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MEDICAL HISTORY

Please Fill Out All Sections and Do Not Fill in the Shaded Areas

Date:			
Last Name:			
First Name:			
Date of Birth:			
Age:			
Marital Status:			
Occupation:			
Who referred you to us?			
Home Address			
Street:			
City:			
State:			
Zip:			
Telephone (home):			
Telephone (cell):			
E-mail:			
List all your doctors names:	Specialty	Address	Phone/ Fax Number

What is your current problem?	

Do you have any medical problems?	No
If "yes", list diagnosis	
Have you had any type of surgery?	No
If "yes", list type, diagnosis and year.	Type / Year

Social History	
Have you ever smoked?	No
If "yes" indicate duration in years:	
How many packs per day?	
Are you still smoking, if not when did you quit?	
Do you drink alcohol?	No
If "yes", average number of drinks/day:	

Any family history of cancer?			No	
If "yes", list relative, age and initial diagnosis:				
Relative	Paternal/Maternal	Age at diagnosis	Type of Cancer?	Current status of relative?
Has any blood relative had any other medical problem?				
Relative	Paternal/Maternal	Age at diagnosis	Type of Medical Problem	Current status of relative?

Are you currently taking any medication?	No
If "yes", what medications and dosage?	

Medication	Dose

Are you allergic to any medications?	No

Medication	Reaction

Additional information
Name of any doctor you have consulted or expect to consult concerning your current problem:
Signature: / *Date:*

Other Comments:

PRE-PROCEDURE SCREENING TOOL

Name: _____

Date of Birth: ___/___/_____ Age: _____ Gender: _____ MRN:_____

Preferred language: _____ Translator requested on day of surgery (circle one)? Yes / No

Surgeon Name (full name): _____ Expected Date of Surgery: ___/___/_____

Expected procedure: _____

Primary Care Physician (full name): _____ Phone: _____

Cardiologist (full name): _____ Phone: _____

Height: _____ (circle one): Ft / Cm Current Weight: _____ (circle one): Lbs / Kg

Preferred number to be called prior to surgery: _____

Best time to call: _____ May we leave a message (circle one)? Yes / No

Please list all current medical conditions:

Please list all allergies (medication, food) and reaction:

Please list all medications you are currently taking (including herbal supplements) and dose:

Please list all prior surgeries and dates:

Please check the boxes below to indicate if you have experienced any of the following problems with prior surgery or anesthesia (you may select more than one):

☐Nausea/vomiting ☐Problems placing breathing tube ☐Nerve injury ☐Slow to wake up after anesthesia

☐Personal/Family history of Malignant Hyperthermia ☐Other: _____

Do you...?	How much/often?	How many years?	If applicable, date quit?
Smoke cigarettes?			
Drink Alcohol?			
Use Recreational Drugs?			

☐I'd prefer to answer in person

IMPLANTS (please bring your wallet card on the day of surgery):

Do you have a pacemaker or an internal defibrillator (circle one)? Yes/No Brand?_____ Last check-up? ___/___/_____

Do you have an artificial heart valve (circle one)? Yes/No ☐Biologic valve ☐Mechanical Valve

Do you have any implantable devices (check all that apply): ☐ PICC ☐Broviac ☐Dialysis catheter ☐Fistula

☐ Other: _____

Please answer the following questions by putting a check mark in the appropriate box (Yes or No):

	Yes	No
Have you ever had a heart attack or cardiac bypass operation?		
Do you have cardiac stents? **If yes, please complete Stent Pre-op Form		
Do you have high blood pressure?		
Have you been diagnosed with congestive heart failure?		
Do you have atrial fibrillation or atrial flutter?		
Can you walk 2 city blocks without stopping due to shortness or breath or chest pain?		
Can you walk up a flight of stairs without shortness of breath or chest pain?		
Do you have COPD or Asthma?		
Do you use a rescue inhaler (Albuterol) more than twice a week?		
Hospitalized for COPD/Asthma attack?		
Do you use supplemental oxygen at home?		
Have you been told your snoring can be heard through closed doors?		
Have you been diagnosed with Obstructive Sleep Apnea (OSA)?		
Do you use a BiPAP or CPAP machine at home?		
Do you have trouble lying flat on your back? If yes: ☐ because of pain ☐ because of breathing difficulty		
Do you have abnormal kidney function?		
Are you on Dialysis?		
Do you have Diabetes?		
Do you take insulin?		
Do you have? ☐ HIV? ☐ Hepatitis A? ☐ Hepatitis B? ☐ Hepatitis C?		
Have you been diagnosed with cirrhosis?		
Have you taken any steroids in the past year?		
Do you have acid reflux?		
Have you ever had a seizure?		
Have you ever had a stroke or surgery on your carotid arteries?		
Do you have any chronic pain that requires daily medication?		
Have you had chemotherapy for cancer?		
Have you ever had radiation to your neck or throat?		
Have you ever had a tracheostomy?		
Do you have trouble opening your mouth or looking up at the ceiling?		
Have you travelled outside of the US in the last two months? Where?		
Have you ever had a blood transfusion?		
Would you accept a blood transfusion if necessary?		
Have you been diagnosed with a bleeding disorder?		
Did you ever have serious bleeding associated with surgery or tooth extraction?		
Have you ever experienced severe bleeding without any reason (nose bleed, gums, etc)?		

- If 1 or more of the bold boxes are checked AND the patient is undergoing high or intermediate risk surgery, it is recommended that the patient has a baseline EKG.
- If 2 or more of the bold boxes are checked, the patient should also be referred to their PMD/Cardiologist or the Anesthesiologist in Pre-Admission Testing.

Patient/Representative Signature: _____ **Date:** ___/___/_____ **Time:** _____AM/PM