NewYork-Presbyterian

INTAKE FORM – PPST
Please print clearly

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

Name:_______________ DOB:_______________ MRN:_______________

Preferred Pharmacy/Phone: _______________ Preferred Phone ( ) _______-_______

Best time to call:_______________ May we leave a message? Yes No

Preferred language:_______________ Do you have sight and/or hearing impairment? Neither Sight Hearing Both

Height (in feet and inches):_______________ Weight (in lbs.):_______________

Referring Provider _______________ Referring Provider Phone _______________

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):

- Severe nausea/vomiting
- Problems placing breathing tube
- Nerve injury
- Slow wake up after anesthesia
- Personal/Family history of Malignant Hyperthermia
- Other:_______________

Do you...?	YES/NO and Detail	How many years?	If applicable, date quit?
Smoke cigarettes/use smokeless tobacco			
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? Yes No Brand?_______ Last check-up?_____/ /_______

Do you have an artificial heart valve? Yes No - Biologic valve __ Mechanical Valve

Do you have any implantable devices (check all that apply): PICC Broviac Dialysis catheter __Fistula __Ventricular device

- Insulin pump
- Other:_______________

50705 (10/16)

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

Question	Yes	No
Have you ever had a heart attack or cardiac bypass operation?		
Do you have stents in any artery in your brain or body? If yes, please ask your surgeon to complete the *Stent Letter*		
Do you have high blood pressure?		
Have you been diagnosed with congestive heart failure?		
Do you have atrial fibrillation or atrial flutter?		
Do you get short of breath or have chest pain when you walk up 1 flight of stairs or 2 city blocks?		
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 diagnosed or suspected to have 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 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 (an incision in windpipe for breathing)?		
Do you have trouble opening your mouth or looking up at the ceiling?		
Have you traveled outside of the US in the last two months? Where?__________________		
Have you ever had a blood transfusion?		
Do you have an objection to blood transfusion if medically necessary?		
Have you been diagnosed with a bleeding disorder?		
Do you have problems with excessive bleeding after surgical or dental procedures?		
If you are a woman of childbearing age, are you or do you believe you may be pregnant?		

Patient/Representative Signature:_________________________________Date:______/______/_________Time:___________AM/PM

*****CLINICIAN USE ONLY*****

- 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.