

Division of Endocrine & Minimally Invasive Surgery

525 East 70th Street, Starr 8 Pavilion, New York, NY 10065

Rasa Zarnegar MD FACS

Office: 212-746-5130 Fax: 212-746-6899 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:	1000 (p) -1		<u>See</u>	1
List all your doctors names:	Specialty	Address		Phone/ Fax Number
	U.			
			-	

Ì.

1

What is your current problem?		
	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.	Туре	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:	

•

۰` ر

Any family history	of cancer?		No	
If "yes", list relative	e, age and initial diagn	osis :		
Relative	Paternal/Maternal	Age at diagnosis	Type of Cancer?	Current status of relative?
Has any blood rela	tive had any other med	lical problem?		
Relative	Paternal/Maternal	Age at diagnosis	Type of	Current status of
			Medical	relative?
			Problem	
	j.			

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

ľ

Are you allergic to any medications?	No		
Medication		Reaction	

5

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

Other Comments:

,

.*

_INEWTOIK-FIESDyteriali

The University Hospital of Columbia and Cornell

PRE-PROCEDURE SCREENING TOOL

Date of Birth:// Age:	Gender:	MRN:
Preferred language:	Translator requested o	n day of surgery (circle one)? Yes /
Surgeon Name (full name):	Expected Date	e of Surgery://
Expected procedure:		<u>.</u>
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: Ma	y we leave a message (circle	one)? Yes / No
Please list all current medical conditions:		

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):

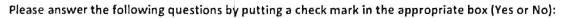
□ Nausea/vomiting □ Problems placing breathing tube □ Nerve injury □ Slow to wake up after anesthesia □ Personal/Family history of Malignant Hyperthermia □ Other: _____

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):

The University Hospital of Columbia and Cornell





	Yes	No
Have you ever had a heart attack or cardiac bypass operation?	Sec. Com	
Do you have cardiac stents? **If yes, please complete Stent Pre-op Form		1
Do you have high blood pressure?		-
Have you been diagnosed with congestive heart failure?	Constanting of the	
Do you have atrial fibrillation or atrial flutter?	0.00	
Can you walk 2 city blocks without stopping due to shortness or breath or chest pain?		100 m
Can you walk up a flight of stairs without shortness of breath or chest pain?		1. Alter
Do you have COPD or Asthma?		
Do you use a rescue inhaler (Albuterol) more than twice a week?	1. The	
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)?	1. And the second	
Do you use a BiPAP or CPAP machine at home?	1	
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?	The second	
Do you have Diabetes?		
Do you take insulin?		
Do you have? 🗆 HIV? 🗀 Hepatitis A? 🗆 Hepatitis B? 🗆 Hepatitis C?	Renautiti	
Have you been diagnosed with cirrhosis?	St. 3	
Have you taken any steroids in the past year?		
Do you have acid reflux?	AND DESCRIPTION	1
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?	10137-11	
Do you have trouble opening your mouth or looking up at the ceiling?	12.18 31	
Have you travelled outside of the US in the last two months? Where?	with a series	
Have you ever had a blood transfusion?	Tapla QABA	
Would you accept a blood transfusion if necessary?		
Have you been diagnosed with a bleeding disorder?	1.5	
Did you ever have serious bleeding associated with surgery or tooth extraction?	Alexiender	
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: