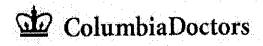


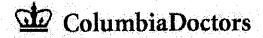
| ast Name: | First Name: | DOB: |
|--|---|--|
| Preferred Phone: | Email: | Gender: |
| Emergency Contact: | | tionship: |
| mergency Contact Phone: | Patie | nt Marital Status: |
| Occupation: | Empl | loyer: |
| Primary Care Provider (PCP): PCP Address: | | PCP Phone: |
| Preferred Pharmacy: | | Pharm Phone: |
| Preferred Pharmacy Address: | | |
| nonitor and improve the quality of care thinicity: Race: Decline Response Decline | e provided to all patients. | health agencies. This information is used to Black or African American Native Hawaiian or Pacific Islander White Decline Response |
| atient Signature: | | Date: |
| nancially responsible and make full pay uthorize my insurance benefits be paid | yment for all charges not d directly to ColumbiaDoc release pertinent medical | due at the time of service. I agree to be covered by my insurance company. I tors for services rendered. I authorize I information to my insurance company whe |
| atient or Guarantor Name (Print): | | |
| atient or Guarantor Signature: | | Date: |
| angangka paggita, ito ana na dibinitah dibinitah bah | dgement of Receipt a copy of the ColumbiaDo | octors Notice of Privacy Practices (NOPP). |
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| | esentative, please print and | <u></u> |
| completed by a patient's personal repre | | THE CONTRACT OF STATE OF THE CONTRACT OF THE C |
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Updated: 11/30/2015



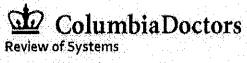
| General Medical Quest | ionnaire | | | |
|---|---|--|--|---|
| Have you EVER had any | PERMITTED AND A SECTION OF THE | | | |
| Asthma/Breathing Prob | lems □Y ⊏ | The term of a party and a state of the | AND BUSH DOMESTIC | O Y 1 |
| Arthritis | | N Lung Disord | der | .,,,, dY i |
| | | N Liver Diseas | se | |
| | | N Neurologic | al Disorder/Chro | onic Headaches 🗅 Y 🕠 |
| | | | | aY |
| | | | | □ Y |
| | | | | .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
| Cholesterol Disorder | oY c | N Seizure or E | Epilepsy | Y |
| Diabetes | DY E | N Thyroid Dis | order | <u> </u> |
| | oma, cataract) 🗆 Y 🛚 | | lney Disorder | Y |
| | dical illnesses or problems a | and provide detail | e for any of the | have conditions |
| Please list any other me | dical illuesses of brookins o | and browing nergii | STOLERLY OF THE | anove conditions. |
| Please list any other me | dical illuesses of broblettis a | anu provide detair | s tot atty of the c | above conditions. |
| Please list any other me | dical illuesses of problems a | anu provide decan | Stor any of the c | aboye conditions. |
| | | | Signally of the | sooye conditions. |
| Please list any surgeries | you have had and the apprecedure | | | omplications |
| Please list any surgeries | you have had and the appr | oximate date. | | |
| Please list any surgeries | you have had and the appr | oximate date. | | |
| Please list any surgeries | you have had and the apprecedure | oximate date. | | |
| Please list any surgeries Pro | you have had and the approcedure | oximate date. Date | | omplications |
| Please list any surgeries Pro | you have had and the apprecedure | oximate date. Date your immediate f | | omplications |
| Please list any surgeries Pro Please indicate any ma Relative | you have had and the approcedure or conditions/illnesses that | oximate date, Date your immediate f | amily members | omplications have had: |
| Please list any surgeries Pro Please Indicate any ma Relative Mother | you have had and the approcedure or conditions/illnesses that Condition and de | oximate date, Date your immediate f | amily members Living? | omplications have had: |
| Please list any surgeries Pro Please indicate any ma Relative Mother Father | you have had and the approcedure or conditions/illnesses that Condition and de | oximate date. Date your immediate feescription | amily members Living? | omplications have had: |
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| Please list any surgeries Pro Please indicate any ma Relative Mother Father Sibling Other: | you have had and the approcedure or conditions/illnesses that Condition and de | oximate date, Date your immediate fescription | amily members Living? DYDN DYDN | omplications have had: If deceased, at what a |
| Please list any surgeries Pro Please indicate any ma Relative Mother Father Sibling Other: | you have had and the approcedure or conditions/illnesses that Condition and de | oximate date. Date your immediate frescription | amily members Living? DYDN DYDN DYDN DYDN Years smoked | omplications have had: If deceased, at what a |

Updated: 11/30/2015



Please list ALL previous physicians who have treated you relevant to your visit (i.e. pulmonologist, oncologist, internist, cardiologist, gastroenterologist, etc...)

| Doctor's Name: Address: | | | |
|--|--|--|--|
| Phone Number: | | Fax Number: | |
| Specialty: | | Pax (Nortiber: | <u> </u> |
| opecially. | * - - - - - - - - - - - - - | | |
| Doctor's Name: | | | |
| Address: | | | |
| Phone Number: | , , , , , , , , , , , , , , , , , , , | Fax Number: | |
| Specialty: | | | |
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| Doctor's Name: | | | |
| Address: | | | |
| Phone Number: | | Fax Number: | |
| Specialty: | | | |
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| Doctor's Name: | | | |
| Address: Phone Number: | | Fax Number: | NEVERNÝ LABOURE BARALLE. PRE CARROL |
| Specialty: | | Fax Nortiber. | |
| specialty, | | | |
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| Doctor's Name: | | | |
| Address: | | | |
| Phone Number: | | Fax Number; | |
| Specialty: | | oralista, praestinia si di Pilita di Pilita | |
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| lanen liek Al I of very express en | adications including | over the counter medications, supple | ments and herbs |
| Medication Name | Dose | Medication Name | Dose |
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| | | | 4 |
| | | | |
| Provider Signature: | | Date: | |
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| Please indicate | ALL that you | have experience | d within the past | 6 – 12 months. |
|---------------------------------|--|------------------------------|-------------------|-------------------|
| all the fact of the contract of | And the state of t | | | 4、1000年2月1日2日1日2日 |
| - 1 to - 1 | | and the second second second | | |

| General | □ None□ Feeling Tired | □ Fever □ Weight Gain | ☐ Chills ☐ Feeling Poorly ☐ Weight Loss |
|------------------|--|------------------------------------|---|
| Eyes | □ None □ Dry Eyes | ☐ Eye Pain ☐ Itchy Eyes | □ Vision Changes □ Eyesight Problems |
| Ear/Nose/Throat | □ None □ Sinus problems | □ Earache □ Sore throat | □ Loss of hearing □ Nose bleeds □ Hoarseness |
| Heart | □ None □ Slow heart rate | ☐ Chest pain☐ Leg swelling | ☐ Palpitations ☐ Fast heart rate ☐ Leg pain, discomfort, fatigue during walking |
| Lungs/Breathing | □ None □ Trouble breathin | ப Cough ng with exertion | □ Wheezing □ Shortness of breath □ Trouble breathing when lying flat |
| Gastrointestinal | □ None □ Heartburn | □ Abdominal pain □ Nausea | □ Constipation □ Diarrhea □ Vomiting □ Blood in stool |
| Bladder | □ None □ Pelvic pain | ☐ Incontinence ☐ Painful period | □ Discolored urine □ Painful urination □ Vaginal Discharge |
| Skin | □ None □ Skin lesions | □ Acne □ Skin wound | ☐ Itching ☐ Change in a mole ☐ Breast pain ☐ Breast lump |
| Neurological | □ None □ Limb weakness | ☐ Confused☐ Loss of memory | ☐ Convulsions ☐ Dizziness ☐ Difficulty walking |
| Psychiatric | □ None □ Suicidal | ☐ Anxiety ☐ Disturbed sleep | ☐ Depression ☐ Change in personality ☐ Emotional problems |
| Endocrine | □ None □ Hair loss | □ Weak muscles □ Hot flashes | □ Feeling weak □ Deepening of voice |
| Hem/Lymph | n None | rı Easy bleeding | n Easy bruising n Swollen glands |

NewYork-Presbyterian



PRE-PROCEDURE SCREENING TOOL Please print clearly

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO. MRN: Name:____ Date of Birth:____/___/ Age:___ Gender (circle one): M / F Preferred Phone: (Your E-mail:____) ____ Best time to call:_____ _____ May we leave a message (circle one)? Yes / No Do you need a translator on the day of surgery (circle one)? Yes / No Preferred language:____ Do you have sight and/or hearing impairment (circle one)? Neither / Sight / Hearing / Both Surgeon (full name): ______ Expected Date of Surgery: _____ / _____/ Expected procedure: ____ Primary Care Physician (full name): Phone: (Cardiologist (full name):_____ Phone: (Height (in feet and inches):_____ Weight (in lbs.):_____ 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:__ If applicable, date quit? How much/often? How many years? Do you...? 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 Do you have any implantable devices (check all that apply): ☐ PICC ☐ Broviac ☐ Dialysis catheter ☐ Fistula ☐ Ventricular device ☐ Insulin pump ☐ Other:__

NewYork-Presbyterian

PRE-PROCEDURE SCREENING TOOL Please print clearly

| | IF NO PLATE, PRINT NAME, SEX AND MEI | DICAL RECORD NO. | |
|---|---|------------------|----------------|
| 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 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? | | | |
| Can you walk 2 city blocks or up 1 flight of stairs without stopping du | e to 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? | | 100000 | |
| Do you use supplemental oxygen at home? | | | |
| Have you been diagnosed or suspected to have Obstructive Sleep A | pnea (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? ☐ Hepatit | is 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 radiation to your neek of throat: Have you ever had a tracheostomy (an incision in windpipe for breat) | hing 12 | | |
| 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? | | | |
| Would you accept a blood transfusion if necessary? | | | |
| Have you been diagnosed with a bleeding disorder? | -1 | | |
| Do you have problems with excessive bleeding after surgical or dent | • | 100 | |
| If you are a woman of childbearing age, are you or do you believe yo | | | |
| If 1 or more of the bold boxes are checked AND the patient is un patient has a baseline EKG. | | | |
| If 2 or more of the bold boxes are checked, the patient should al Admission Testing. | so be referred to their PMD/Cardiologist or | the Anesthesia | logist in Pre- |
| Patient/Representative Signature: | Date:/ | Time: | AM/PM |

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