NAME: _____

Last First

M.I.

Have you ever been treated for HIGH BLOOD PRESSURE? Yes No If yes, explain: Yes No DIABETES? Yes No Do you take insulin? Yes No Type 2 Yes No History of ANY SMOKING Yes No Examples: cigarettes, vape, cannabis, cigars, ect. Yes No If yes, How often: Yes No When did you quit? Any BREATHING DISORDER? Ex. Asthma, Sleep Apnea, Etc. Yes No Have you ever been seen by a pulmonologist? (lung specialist) Yes No No Have you ever been seen by a cardiologist? (heart specialist) Yes No No Have you ever been seen by a cardiologist? (heart specialist) Yes No No Have you ever been seen by a cardiologist? (heart specialist) Yes No No Have you ever bead a BLOOD CLOT/DVT/ PE? Yes No No Have you ever bad a BLOOD CLOT/DVT/ PE? Yes No If yes, explain: Yes No No Any BLOOD DISORDERS? (clotting disorders, sickle cell, etc) Yes No If yes	Check all that have ever applied to you (Present or Past)		
Do you take insulin? Yes No Type 1 Yes No History of ANY SMOKING Yes No Examples: cigarettes, vape, cannabis, cigars, ect. Yes No When did you quit? Yes No Any BREATHING DISORDER? Ex. Asthma, Sleep Apnea, Etc. Yes No If yes, explain: Yes No Have you ever been seen by a pulmonologist? (lung specialist) Yes No Have you ever been seen by a cardiologist? (heart specialist) Yes No Have you ever been seen by a cardiologist? (heart specialist) Yes No Have you ever been seen by a cardiologist? (heart specialist) Yes No Have you ever had a BLOOD CLOT/DVT/ PE? Yes No History of EXCESSIVE BLEEDING OR ANEMIA (low blood count) Yes No If yes, explain: Yes No No Any HLOOD DISORDERS? (clotting disorders, sickle cell, etc) Yes No If yes, explain: Yes No No Any AUTOIMMUNE CONDITIONS? Examples: Lapus, theumatoid arthritis, etc. Yes No If yes, explain: No Yes		Yes	No
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	Any REACTIONS TO ANESTHESIA?	Yes	No

None

• List all **current medications taken** (including dosage & frequency taken): None

(include herbal supplements, vitamins, dietary aids, aspirin, etc.- anything taken regularly)

• List Medication Allergies (include drug name and reaction)

None

I request direct payment of authorized medical benefits be made to Dr. Woodyard for any services furnished me by said physician. I permit a copy of this consent to be used in place of the original copy. This assignment will remain in effect until I revoke, in writing, this consent. I understand I am responsible for paying the portion due according to the contract of my insurance carrier. If no insurance exists, whether due to lapse/termination of coverage or simply lack of coverage, I understand I am financially responsible for all charges for services performed for me or my legal dependent.

I give consent for the use and disclosure of Private Healthcare Information to be used for treatment, payment, and healthcare operations on my behalf (refer to "Notice of Privacy Practices" for information on how this office handles patient private documents). I acknowledge receipt of "Notice of Privacy Practices (additional copies in the Waiting Room).

Signature

Date

Updated_____
