NAME: _____
Last First M.I.

Check all that have ever applied to you (Present or Past)

Have you ever been treated for **HIGH BLOOD PRESSURE**? If yes, explain:	Yes	No
DIABETES? Do you take insulin? Yes No Type 1 Yes No Type 2 Yes No	Yes	No
History of ANY **SMOKING** Examples: cigarettes, vape, cannabis, cigars, ect. If yes, How often: When did you quit?	Yes	No
Any **BREATHING DISORDER**? Ex. Asthma, Sleep Apnea, Etc. If Yes, explain:	Yes	No
Have you ever been seen by a pulmonologist? (lung specialist) If yes, explain:	Yes	No
Any **CARDIAC/HEART CONDITIONS**? Examples: Heart failure, heart attack, stents, etc. If yes, explain:	Yes	No
Have you ever been seen by a cardiologist? (heart specialist) If yes, explain:	Yes	No
Have you ever had a **BLOOD CLOT/DVT/ PE**? If Yes, Explain:	Yes	No
History of **EXCESSIVE BLEEDING OR ANEMIA** (low blood count) If yes, explain:	Yes	No
Any **BLOOD DISORDERS**? (clotting disorders, sickle cell, etc) If yes, explain:	Yes	No
Any **THYROID CONDITIONS**? If yes, explain:	Yes	No
Any **AUTOIMMUNE CONDITIONS**? Examples: Lupus, rheumatoid arthritis, etc. If yes, explain:	Yes	No
Any **OTHER ILLNESSES**? Examples: cancer, stroke, seizures, hepatitis, immune deficiency disorders, etc. If yes, explain:	Yes	No
Have you ever seen any other specialists? Examples: Hematologist, Endocrinologist, Rheumatologist etc. If yes, explain:	Yes	No
Any history of **COVID ILLNESS**? If yes, explain:	Yes	No
Any conditions which require you to take antibiotics before surgery/ dental work? If yes, explain:	Yes	No
LATEX ALLERGY	Yes	No
Any **REACTIONS TO ANESTHESIA**? If yes, Explain:	Yes	No

- **List all prior operations** (include year of surgery) 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_____
_____
_____