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Otorhinolaryngology **Head and Neck Surgery**

Date:

PATIENT MEDICAL INFORMATION

Patients' Name: ____________________
Sex F / M Age _____ Birth Date __________ HT ______ WT ______ TEMP ______VITALS______

List any allergies to medications and/or food:

____

Briefly describe your present problem and how long it has caused you problems:

____

Prior Medical History:

- ___Heart Attack/Heart Disease
- ___Congestive Heart Failure
- ___Hypertension
- ___COPD/Lung Disease
- ___Stroke
- ___HIV/AIDS
- ___Seizures
- ___Diabetes
- ___Sleep Apnea
- ___Asthma
- ___Arthritis
- ___Glaucoma/Cataracts
- ___Tuberculosis
- ___Cancer (specify) ____________
- ___Liver/Kidney Disease (specify) ____________
- ___Spine Disorders (specify) ____________
- ___Thyroid Disorders (specify) ____________
- ___Bleeding/Clotting Disorder (specify) ____________

Please check following current complaints:

Constitutional: ___Weight Loss ___Fever ___None
Eyes: ___Vision Change ___None
Respiratory: ___Wheezing ___Shortness of Breat___None
Cardiovascular: ___Chest Pain ___Palpitations ___None
Gastrointestinal: ___Heartburn ___ Nausea ______None
Genitourinary: ___Painful Urination ___Blood in Urine ___None
Musculoskeletal: ___Joint Pain ___None
Skin: ___Lesions on Skin ___None
Neurological: ___Numbness ___Weakness ___Seizures ___None
Psychiatric: ___Depression ___Anxiety ___Sleep Disorder ___None
Endocrine: ___Temperature Intolerance ___None
Hematologic/Lymph nodes: ___Blood Clotting Disorder ___None
Allergic/Immunologic: ___Sneezing ___Eye Irritation ___None

Problems not listed above? ____________________
Do you drink alcohol? ____________ How much daily? ____________
Caffeine drinks? ____________ How many daily? ____________
Do you smoke? _________ How much? ____________ Quit? _________ When? ____________

Current Medications____________________

Preferred Pharmacy:____________ **Location and Number:**____________

List all prior surgeries with the year in which they were performed:

____

Any anesthesia related problems? ___________ If so, what type? ____________

Family History: Cancer________ Diabetes_______ High Blood Pressure________ Heart Disease ____________
Problems not listed? ____________________

Birth History: (for Patients under the age of 18 only)

Was the child born on time? _________ Problems during Mother's Pregnancy? ____________

Breathing problems at birth? _________ Immunizations current? ____________

History of: Asthma ____________ Reflux ____________ Seizures____________