



1250 8th Ave, Ste 135 | Fort Worth, TX 76104  
Phone: 817.332.8848 | Fax: 817.335.2670

Jeremy P. Watkins, MD  
J. Brad McIntyre, MD  
Sean M. Callahan, MD

Otorhinolaryngology | Head & Neck Surgery

**PATIENT MEDICAL INFORMATION**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Sex: M / F Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**FOR OFFICE USE ONLY:** Temperature: \_\_\_\_\_ 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 Type) \_\_\_\_\_
- \_\_\_\_ Liver/Kidney Disease (Specify Type) \_\_\_\_\_
- \_\_\_\_ Spine Disorders (Specify Type) \_\_\_\_\_
- \_\_\_\_ Thyroid Disorders (Specify Type) \_\_\_\_\_
- \_\_\_\_ Bleeding/Clotting Disorders (Specify Type) \_\_\_\_\_

**Please check if any of the following complaints apply:**

- Constitutional: \_\_\_\_\_ Weight Loss \_\_\_\_\_ Fever \_\_\_\_\_
- Eyes: \_\_\_\_\_ Vision Change \_\_\_\_\_
- Respiratory: \_\_\_\_\_ Wheezing \_\_\_\_\_ Shortness of Breath \_\_\_\_\_
- Cardiovascular: \_\_\_\_\_ Chest Pain \_\_\_\_\_ Palpitations \_\_\_\_\_
- Gastrointestinal: \_\_\_\_\_ Heartburn \_\_\_\_\_ Nausea \_\_\_\_\_
- Genitourinary: \_\_\_\_\_ Painful Urination \_\_\_\_\_ Blood in Urine \_\_\_\_\_
- Musculoskeletal: \_\_\_\_\_ Joint Pain \_\_\_\_\_
- Skin: \_\_\_\_\_ Lesions on Skin \_\_\_\_\_
- Neurological: \_\_\_\_\_ Numbness \_\_\_\_\_ Weakness \_\_\_\_\_ Seizures \_\_\_\_\_
- Psychiatric: \_\_\_\_\_ Depression \_\_\_\_\_ Anxiety \_\_\_\_\_ Sleep Disorder \_\_\_\_\_
- Endocrine: \_\_\_\_\_ Temperature Intolerance \_\_\_\_\_
- Hematologic/Lymphnodes \_\_\_\_\_ Blood Clotting Disorder \_\_\_\_\_
- Allergic/Immunologic \_\_\_\_\_ Sneezing \_\_\_\_\_ Eye Irritation \_\_\_\_\_

Problems not listed above? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ How much daily? \_\_\_\_\_

Caffeinated beverages? \_\_\_\_\_ How much daily? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How much? \_\_\_\_\_ Quit? \_\_\_\_\_ When? \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Location & Phone#: \_\_\_\_\_

Current Medications: \_\_\_\_\_

List all prior surgeries with the year they were performed: \_\_\_\_\_

Any anesthesia-related problems? \_\_\_\_\_ If so, what type? \_\_\_\_\_

**Please list which immediate family members have the following:**

Family History: Cancer \_\_\_\_\_ Diabetes \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Heart Disease \_\_\_\_\_

Problems not listed? \_\_\_\_\_

**Birth History: (for patients under the age of 18)**

Was the child born on time? \_\_\_\_\_ Problems during mothers pregnancy? \_\_\_\_\_

Breathing problems at birth? \_\_\_\_\_ Immunizations current? \_\_\_\_\_

History of: Asthma \_\_\_\_\_ Reflux \_\_\_\_\_ Seizures \_\_\_\_\_