Please answer this questionnaire to the best of your knowledge. Information is confidential and will be used by your care providers to evaluate and treat your medical problems.

THE EAR, NOSE AND THROAT CLINIC & HEARING CENTER | RENEW FACIAL PLASTIC SURGERY

Adult Medical History Form

Please print (if you do not understand a question, leave it blank)

Today's date _____

PATIENT NAME _____
(First) (M) (Last) (Date of birth)

Name of your regular physician: _____ Clinic: _____

1. CHRONIC MEDICAL PROBLEMS (high blood pressure, high cholesterol, diabetes, etc.)

_____

_____

2. PRIOR SURGERIES

_____ Date _____ _____ Date _____

_____ Date _____ _____ Date _____

3. BLOOD CONDITIONS

a. Have you had hepatitis? No____ Yes____ Date _____ a. Have you been tested for HIV? No____ Yes____ Results (optional) ____

c. Have you had a blood transfusion? No____ Yes____ Date _____ d. Do you have blood clotting or bruising problems? No____ Yes ____

4. MEDICATIONS

a. Are you currently taking any prescription medications? No____ Yes____ Please list: _____

_____

b. Are you currently taking any over-the-counter medications? No____ Yes____ Please list: _____

_____

5. ALLERGIES

a. Are you allergic to any medications? No____ Yes____ Please list: _____

b. Do you have environmental allergies/hay fever? No____ Yes____ c. Have you been tested for allergies? No____ Yes ____

d. Do you have food sensitivities? No____ Yes____ Which foods? _____

e. Other allergies? _____

6. Do you smoke? No____ Yes____ How many packs per day for how many years? _____ If you quit, when? _____

7. Do you drink alcoholic beverages? No____ Yes____ How many drinks per week? _____ Or month? _____

8. FAMILY HISTORY

Mother living No____ Yes____ Died of: _____ Father living No____ Yes____ Died of: _____

Family history of ear or hearing problems? No____ Yes____ Details: _____

Family history of allergy? No____ Yes____ Details: _____

9. REVIEW OF SYSTEMS Please circle "Y" or "N" for any symptoms you currently do / do not have

GENERAL:		RESPIRATORY:		GASTROINTESTINAL:	
Unexplained fevers/night sweats	Y / N	Persistent cough	Y / N	Nausea/vomiting	Y / N
Unintentional weight loss	Y / N	Hoarseness	Y / N	Heartburn/acid reflux	Y / N
SKIN:		Shortness of breath	Y / N	EYES:	
Change in moles	Y / N	MUSCLE/JOINT/BONE:		Blurred vision	Y / N
Sore that won't heal	Y / N	Pain, weakness or numbness in:		Double vision	Y / N
ENT:		Arms/legs	Y / N	HEME/LYMPH:	
Difficulty swallowing	Y / N	Back/neck	Y / N	Enlarged lymph nodes	Y / N
Ear pain/drainage	Y / N	NEUROLOGIC:		Excessive bleeding	Y / N
Nosebleeds	Y / N	Headache	Y / N	CARDIOVASCULAR:	
Hearing loss	Y / N	Numbness/tingling	Y / N	Chest pain	Y / N
Ringing in ears	Y / N	ALLERGY/IMMUNOLOGY:		Irregular heartbeat	Y / N
Sinus problems	Y / N	Decreased immunity	Y / N	Heart murmur	Y / N
		Hay fever	Y / N		

Physician use only: Date/Initials _____