

PATIENT INFORMATION

Name _____ Age _____ Sex _____ Date _____
 Preferred Designation _____ S.S# _____ Driver's Lic# _____
 Birthdate _____ Single _____ Married _____ Widowed _____ Divorced _____
 Address _____
 City _____ State _____ Zip _____
Home Phone Number() _____ **Work Phone Number** () _____ **Cell Number** () _____
 Occupation: _____
 Who is the responsible party: _____ Employer: _____
 Person to contact in case of emergency: _____ (_____) _____
 Referred by: _____
 Purpose of Consultation: _____

I. MEDICAL QUESTIONNAIRE: (Please indicate with a "X" all that apply)

Have you ever had any heart problems?	High blood pressure _____	Have you ever had gastrointestinal problems?	Ulcers _____
	Low blood pressure _____		Gastritis _____
	Heart attack _____		Colitis _____
	Heart murmur _____		Diverticulitis _____
	Chest pain/tightness _____		
	Irregular heart beat _____		
	Shortness of breath _____		

Have you ever had Any eye, ear, nose or throat problem?	Dry eyes _____	Have you ever had any hematologic/metabolic problems?	Anemia _____
	Blurred Vision _____		Bleeding problems _____
	Glaucoma _____		Blood Transfusions _____
	Corrective lenses _____		AIDS virus exposure _____
	Ear disease _____		Autoimmune disease _____
	Nosebleeds _____		Diabetes _____
	Difficulty breathing _____		Thyroid disease _____
	Nasal allergies _____		Depression _____
Sinus disease _____	Have you ever been treated for psychiatric/emotional problems?	Anxiety _____	
Other _____		Other _____	

Do you have any medical problems that have not been covered? _____ (Explain below)
 Do you smoke cigarettes? _____ How much _____
 Do you drink alcoholic beverages? _____ Socially _____ Daily _____
 Do you take any recreational drugs? _____
 Patient height _____ Patient weight _____
 Do you take any diet medication? _____

II. MEDICAL HISTORY

Name & city of your personal physician _____

Are you presently under the care of a physician for any medical condition? _____

A. SURGICAL HISTORY – Please list all previous surgeries (including cosmetic)

Operation	Surgeon Name	Year of Operations
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

B. HOSPITALIZATIONS (other than for surgery)

Illness	Physician/Date
_____	_____
_____	_____
_____	_____

II- MEDICATIONS & VITAMINS / DIETS PILLS

Name of Drug	Strength/Dosage	Condition treated
_____	_____	_____
_____	_____	_____
_____	_____	_____

IV. ALLERGIES: (Please list any allergies to any medications, tapes, or antiseptic cleansers or Latex allergies)

V. FAMILY HISTORY: (Please indicate if any immediate family member has ever had any of the following?)

- Heart disease _____
- Bleeding disorder _____
- Diabetes _____
- Autoimmune disease _____
- Anesthetic Complications _____
- Others _____

Date: _____

Patient Signature

Clinic Staff Signature