



**MEDICAL HISTORY**

In an effort to serve you better, we request that you provide us with the following information. All information is held strictly confidential and is released only with your written consent.

Last Name	First	Age	Sex	Referring Physician
Presenting Problem or Proposed Surgery				
<b>ILLNESS/INJURY: Please check if you have ever had:</b>				<p><b>Physician Notes</b> Please do not write in this area.</p>
<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>OPERATIONS: Please list operations you have had.</b>				<input type="checkbox"/> <b>NONE</b>
<b>Year</b>	<b>Name of Operation</b>	<b>Type of Anesthetic (if known)</b>	<b>Complications</b>	
Have you ever had a blood transfusion? <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____				
List any hospital admissions or medical conditions not listed above: _____				
<b>DRUGS: Please list all drugs you take and their dosages.</b>				<input type="checkbox"/> <b>NONE</b>
<b>Drug</b>	<b>Dosage</b>	<b>Drug</b>	<b>Dosage</b>	
<b>ALLERGIES: Please list type and reaction.</b>				<input type="checkbox"/> <b>NONE</b>
<b>Name of Drug</b>	<b>Reaction</b>	<b>Name of Drug</b>	<b>Reaction</b>	
Do you smoke or have you ever smoked? <input type="checkbox"/> No <input type="checkbox"/> Quit: _____ mo./yrs. ago <input type="checkbox"/> Yes: _____ packs/day x _____ years				
Do you drink alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes - rarely/occasionally/daily: _____ drinks/day				
Have you ever been a heavy drinker? <input type="checkbox"/> No <input type="checkbox"/> Yes How long ago? _____				
FEMALES ONLY: Are you pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes				
The above information is true and accurate. (Parent signature required if patient is a minor)				
Patient Signature _____ Date _____				

**(Continued on back)**



\*TO BE COMPLETED BY PATIENT\*

Patient Name \_\_\_\_\_

**FAMILY HISTORY: Please check if you have a family history of:**

Yes	No	Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**HEAD/NECK SYMPTOM REVIEW: Are you currently having:**

Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Physician Notes**  
Please do not write in this area.

DATE: \_\_\_\_\_

**History & Physical Examination (to be completed by the physician)**

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\_\_\_\_\_

\_\_\_\_\_

**General:**

**Ears:** (R) \_\_\_\_\_  
(L) \_\_\_\_\_

**Nose:** septum \_\_\_\_\_  
turbينات \_\_\_\_\_  
mucosa \_\_\_\_\_  
d/c \_\_\_\_\_  
sinus tenderness \_\_\_\_\_

**Nasopharynx:**

**Mouth/Oropharynx:**

mucosa \_\_\_\_\_  
tonsils \_\_\_\_\_  
tongue \_\_\_\_\_

**Larynx/Hypopharynx:**

**Neck**

**Face**

**CN II-XII**

**I/P**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

