New York Otology
Sujana S. Chandrasekhar, M.D., F.A.C.S.

NAME_____ D.O.B._____

WHAT IS YOUR MAIN COMPLAINT:_____

WHO IS YOUR REFERRING DOCTOR:_____

Please Specify

Do you have or have you had any of the following?:

A. Rheumatic fever or rheumatic heart disease.....	Yes	No
B. Congenital heart disease.....	Yes	No
C. Cardiovascular disease		
Stroke, angina, arteriosclerosis, high blood pressure, low BP.....	Yes	No
D. A Cardiac pacemaker.....	Yes	No
E. Sinus trouble.....	Yes	No
F. Asthma, hay fever.....	Yes	No
G. Neurological disorders (epilepsy, seizures, fainting).....	Yes	No
H. Diabetes.....	Yes	No
I. Liver disease (hepatitis, jaundice).....	Yes	No
J. Arthritis.....	Yes	No
K. Stomach disease (including ulcers).....	Yes	No
L. Intestinal disease (including polps).....	Yes	No
M. Kidney disease.....	Yes	No
N. Lung disease (including tuberculosis, pneumonia).....	Yes	No
O. Venereal disease.....	Yes	No
P. Blood disease (including anemia).....	Yes	No
Q. HIV or AIDS.....	Yes	No
R. Do you bleed excessively.....	Yes	No
S. Other_____	Yes	No

Have you been hospitalized or had any surgery? Yes No

If yes, for what?_____

_____

What medications are you presently taking?_____

_____

Have you ever been given antibiotics by injection?.....Yes No

Are you allergic to, or have you reacted badly to:

A. local anesthetics.....	Yes	No
B. Penicillin or antibiotics.....	Yes	No
C. Sulfas.....	Yes	No
D. Sedatives (Sleeping pills, barbiturates).....	Yes	No
E. Aspirin.....	Yes	No
F. Codeine or other narcotics.....	Yes	No