MANHATTAN OTOLARYNGOLOGY – HEAD AND NECK SURGERY

Patient Name:

____

Height_____ **Weight**_____ **Temp**_____ **Bp**_____ **Pulse** _____

Please list ALL PAST SURGERIES:

____

____

____

ANESTHESIA Problems: Yes No

If yes please list:

____

Please list All MEDICATIONS, including dosage:

____

____

____

List any ALLERGIES (medications/food/inhalant):

____

____

Please list any non-prescription medications:

____

____

Please list any Herbal: (e.g. Ginkgo, Ginseng, Echinacea)

____

____

Do you smoke? **Yes** **No**

Did you previously smoke? **Yes** **No**

Packs per day: ______ **for**______ **years** **Quit**____

Do you drink alcohol? **Yes** **No**

Numbers of drinks per week_______

Do you use recreational drugs? **Yes** **No**

Please list_________________ How often_______________

DATE: _____ **SIGNATURE**_________________________

Please check any symptoms you have recently experienced

___Ear pain ___Hearing loss ___Cough ___Congestion

___ Headache ___Facial Pain ___Weakness ___Fatigue

Please list ALL YOUR medical conditions:

___ Anxiety ___ Kidney disease

___ Arthritis ___ Liver disease

___ Asthma ___ Pacemaker

___ bleeding problems ___ palpitations/irregular heart

___ Bronchitis ___ Pneumonia

___ Chest pain ___ Reflux

___ COPD ___ Seizure

___ Depression ___ Shortness of breath

___ Diabetes ___ Sickle Cell

___ Excessive bruising ___ Sleep Apnea

___ Glaucoma ___ Stroke

___ Heart Attack ___ TB

___ Heat/Cold problems ___ Thyroid disease

___ Hiatal hernia ___ Ulcer

___ High blood pressure ___ Urinary problems

___ High cholesterol ___ IBS

Family History of Medical Conditions:

___ Asthma ___ Heart

___ Cancer ___ High blood pressure

___ Diabetes ___ Stroke

___ Emphysema ___ Other: _______________

List your Primary Care Physician:

Name________________________________

Address______________________________

____

Telephone____________________________