New Patient Information
Department of Otolaryngology –
Head & Neck Surgery

Attach Patient Label Here

Visit Date:_____

Patient Name: Age: Data of Birth:

Parent/Guardian (if patient is minor):

Address:

E-mail Address;

Home Telephone Number ( ) Alternate Number ( )

Refemng Physician:
Name:

Address:

Phone

Family Physician:
Name:

Address:

Phone

Health Problem Prompting Today's Visit

Personal Medical History:

Please list past and current medical problems:

Please list past surgeries:

Please list all current medications (prescription and non-prescription), vitamins, and herbs:

Medication allergies: None_____ **Yes_____** please list:

PLEASE CONTINUE ON REVERSE SIDE

Occupation: _____

Have you ever used the following substances?

Tobacco, any form: No___Yes___If yes, which form?_____

If stopped, when?_____How much per day?_____

Alcohol: No___ Yes___ How much per day?_____

Street drugs: No___ Yes___ What and how often?_____

Please list any important diseases that are prevalent in your family:

Do you have problems with your:

Blood Pressure	No____Yes____Explain_____
Heart	No____Yes____Explain_____
Lungs	No____Yes____Explain_____
Stomach/Bowels	No____Yes____Explain_____
Kidney/Urinary Tract	No____Yes____Explain_____
Muscles/Joints	No____Yes____Explain_____
Skin	No____Yes____Explain_____
Eye/Vision	No____Yes____Explain_____
Diabetes/Thyroid	No____Yes____Explain_____
Allergic/Immune	No____Yes____Explain_____
Infections	No____Yes____Explain_____
Neurological Problems	No____Yes____Explain_____
Psychological	No____Yes____Explain_____
General	No____Yes____Explain_____
(Weight loss, Fevers)	No____Yes____Explain_____

Physician Review_____Date:_____

Vital signs: BP____/____ Pulse_____ Resp_____Temp____Wt____Ht_____

Pain Rating Scale (1=Pain Free; 10=Most Severe) Please Circle:

1 2 3 4 5 6 7 8 9 10

Physician Notes: