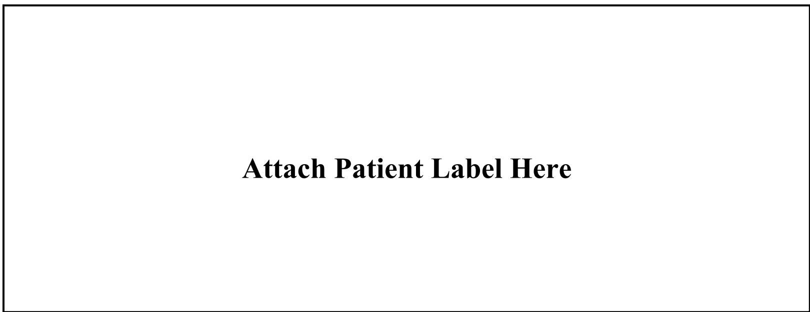

New Patient Information
Department of Otolaryngology –
Head & Neck Surgery

Visit Date:_______________
Patient Name:____Age:________Date of Birth:____________
Parent/Guardian (if patient is minor):____
Address:____
____
E-mail Address:____
Home Telephone Number:(___)__________________Alternate Number:(___)________________________

Referring 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 Problems No__Yes__Explain_____________________________________
General:
(Weight loss, Fevers) No__Yes__Explain______________________________________

Physician Review________________,Date__________

Vital signs: BP_____/_____Pulse________Resp________Temp________Wt________Ht________

Pain Rating Scale (0=Pain Free, 10=Most Severe) Please Circle:

0	1	2	3	4	5	6	7	8	9	10

Physician Notes:

____

____

____

____

____

____

____

____