

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: _____ Family Physician: _____

Name: _____ Name: _____

Address: _____ Address: _____

Phone _____ 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: