

**New Patient Information**  
**Department of Otolaryngology –**  
**Head & Neck Surgery**



**Attach Patient Label Here**

Visit Date: \_\_\_\_\_  
Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Parent/Guardian (if patient is minor): \_\_\_\_\_  
Address: \_\_\_\_\_

E-mail Address: \_\_\_\_\_  
Home Telephone Number:(\_\_\_\_) \_\_\_\_\_ Cell #:(\_\_\_\_) \_\_\_\_\_ Work #:(\_\_\_\_) \_\_\_\_\_

Referring 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:  
\_\_\_\_\_

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

Medication allergies: None \_\_\_\_\_ Yes, \_\_\_\_\_, please list:  
\_\_\_\_\_

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

**Do you or a family member have:**

Problems with hearing or ear infections? Yes\_\_\_\_ No\_\_\_\_  
Nasal breathing, recurring sinus infections or nasal allergies? Yes\_\_\_\_ No\_\_\_\_  
Hoarseness or difficulty swallowing? Yes\_\_\_\_ No\_\_\_\_  
Snoring? Yes\_\_\_\_ No\_\_\_\_  
Non-healing sores or ulcers in your mouth? Yes\_\_\_\_ No\_\_\_\_  
Lump in the neck or goiter? Yes\_\_\_\_ No\_\_\_\_

Are you interested in improving the appearance of your eyes, nose, face, neck or hair? Yes\_\_\_\_ No\_\_\_\_

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 CONTINUE ON THE BACK**

