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# MEDICAL FACULTY ASSOCIATES

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Duration of problem: \_\_\_\_\_

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

\_\_\_\_\_  
(name, address, phone number)

**Medications:** (with strength and dosage)

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

**Illnesses** for which you take medications or for which you have been hospitalized, such as high blood pressure, diabetes, etc.

1.	5.
2.	6.
3.	7.
4.	8.

**Surgery** you have had, in order from most recent (include dates):

1.	5.
2.	6.
3.	7.
4.	8.

Are you **allergic** to or have you had severe reactions to any *medications* or *foods*?  
Yes  No  If yes, for which medications or foods?

Do you or did you ever **smoke**? Yes  No  Packs per day \_\_\_\_\_  
How many years? \_\_\_\_\_ If you quit, when? \_\_\_\_\_

Do you drink **alcoholic beverages**? Yes  No  Amount \_\_\_\_\_

Are you **pregnant** or nursing? Yes  No  N/A

**Comments:** \_\_\_\_\_

DIVISION OF OTOLARYNGOLOGY / HEAD AND NECK SURGERY  
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**MEDICAL/SURGICAL HISTORY (check all that apply)**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Weight loss of 20 lbs. or more | <input type="checkbox"/> Lupus                              | <input type="checkbox"/> High blood pressure  |
| <input type="checkbox"/> Environmental allergy          | <input type="checkbox"/> Rheumatoid arthritis               | <input type="checkbox"/> Angina or chest pain |
| <input type="checkbox"/> Peripheral vascular disease    | <input type="checkbox"/> Vaginal infection                  | <input type="checkbox"/> Anemia               |
| <input type="checkbox"/> Shortness of breath            | <input type="checkbox"/> Pregnancy                          | <input type="checkbox"/> Diarrhea             |
| <input type="checkbox"/> Cough / coughing blood         | <input type="checkbox"/> Fracture                           | <input type="checkbox"/> Constipation         |
| <input type="checkbox"/> Lung disease                   | <input type="checkbox"/> History of trauma / assault        | <input type="checkbox"/> Nausea               |
| <input type="checkbox"/> COPD / emphysema               | <input type="checkbox"/> Muscle weakness / disease          | <input type="checkbox"/> Vomiting             |
| <input type="checkbox"/> Asthma                         | <input type="checkbox"/> Seizures                           | <input type="checkbox"/> Diabetes             |
| <input type="checkbox"/> Tuberculosis                   | <input type="checkbox"/> Paralysis / stroke                 | <input type="checkbox"/> Thyroid disease      |
| <input type="checkbox"/> Double / Blurred vision        | <input type="checkbox"/> Wounds                             | <input type="checkbox"/> Rash                 |
| <input type="checkbox"/> Heartburn / reflux             | <input type="checkbox"/> Skin breakdown                     | <input type="checkbox"/> Bruises              |
| <input type="checkbox"/> Stomach ulcers                 | <input type="checkbox"/> Numbness/tingling of hands or feet | <input type="checkbox"/> Fever / chills       |
| <input type="checkbox"/> Urinary tract infections       | <input type="checkbox"/> Psychological problems             | <input type="checkbox"/> Night sweats         |
| <input type="checkbox"/> Problems passing urine         | <input type="checkbox"/> Anxiety                            |   |

Other medical problems, please list: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you or any blood relatives have a **bleeding problem** with surgery or cuts? Yes  No

Do you take aspirin, ibuprofen, herbal medication, or similar **blood thinners**? Yes  No

Medical problems that run in the **family** (diabetes, high blood pressure, high cholesterol):

\_\_\_\_\_

**MEDICAL PROBLEMS INVOLVING THE HEAD AND NECK:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Hearing loss        | <input type="checkbox"/> Nose bleed          | <input type="checkbox"/> Sores (mouth, throat, neck) |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Sinus drainage      | <input type="checkbox"/> Difficulty swallowing       |
| <input type="checkbox"/> Drainage            | <input type="checkbox"/> Sinus congestion    | <input type="checkbox"/> Hoarseness                  |
| <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Difficult to breath | <input type="checkbox"/> Lumps (mouth, throat, neck) |

Other ear, nose, mouth, throat, or neck problems: \_\_\_\_\_

\_\_\_\_\_

Is there any other information you think we should know? \_\_\_\_\_

\_\_\_\_\_