FRIEDMAN PLASTICS & ENT HISTORY FORM

Patient Name____Date_______________________

Gender Male □ Female □ Prefer not to state □ Date of Birth_________________________

Height:_____________ Weight: _______________ BP:__________________

Reason for Visit: Plastics Consultation □ ENT appointment □ Other □ State below

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SOCIAL HISTORY:

Occupation: ____

Smoker: □ NO □ YES Pack per day ____ Number of years smoked: ____ Quit when? _______

Alcohol: □ NO □ YES □ Occasionally Drug Use or Addiction: □ NO □ YES □ PAST

IMMUNIZATION

Influenza □ NO □ YES Date:_____________ Pneumonia □ NO □ YES Date:_____________

ALLERGIES: □ NONE □ YES (Please note/circle the reaction for each allergy) **LATEX ALLERGY** □ NO □ YES

Allergic to: ______________________________HIVES AIRWAY ISSUES SWELLING OF ______________________________

Allergic to: ______________________________HIVES AIRWAY ISSUES SWELLING OF ______________________________

OTHER: ____

SHELLFISH OR IODINE ALLERGIES: □ NO □ YES TAPE OR ADHISIVE ALLERGIES: □ NO □ YES

CURRENT MEDICATIONS: □ NO □ YES COPY OF MEDICATION LIST □ NO □ YES

PLEASE LIST ALL MEDICATIONS INCULDING BIRTHCONTROL, VITAMINS, AND OVER THE COUNTER ON THE BACK OF THIS PAGE.

Do you have Advanced Directives? □ NO □ YES (PLEASE SEE OUR POLICY FOR ADVANCE DIRECTIVES)

MEDICAL HISTORY: □ NONE □ CANCER □ HEART DISEASE □ RESPIRTORY PROBLEMS □ OTHER:

____

ARE YOU DIABETIC? □ NO □ YES INSULIN OR PILLS

ANY MEDICAL CONDITIONS or DIAGNOSIS/DISEASE THAT WE NEED TO KNOW ABOUT? □ NO □ YES (LIST BELOW)

____

CONTINUE ON NEXT PAGE.

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HAVE YOU HAD ANY SURGERIES □ NO □ YES (Cosmetic/ medical necessary or C-SECTION) *PLEASE LIST ON NEXT PAGE

SURGICAL HISTORY: □ IMPLANTS/ DEVICES (Please list any foreign implant including hip; metal plates; screws; dental implants; saline or silicone body implants; pace maker)

Any complications with anesthesia? □ NO □ YES PLEASE EXPLAIN:

____

____

Do you have children? □ NO □ YES

BIRTH CONTROL □ NO □ YES □ MENOPAUSE On set age: _________

□ STERILIZED TYPE: ____

MEDICATION LIST:	REASON:
1. ______________________________	______________________________
2. ______________________________	______________________________
3. ______________________________	______________________________
4. ______________________________	______________________________
5. ______________________________	______________________________
6. ______________________________	______________________________
7. ______________________________	______________________________
8. ______________________________	______________________________
9. ______________________________	______________________________
10. ______________________________	______________________________

LIST OF SURGICAL PROCEDURES:

____ MONTH/YEAR ______________________

____ MONTH/YEAR ______________________

____ MONTH/YEAR ______________________

____ MONTH/YEAR ______________________

____ MONTH/YEAR _________________

By signing below, I have provided everything to the best of my knowledge

Signature _______________________________________Date_________________