

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

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**IMMUNIZATION**

Influenza  NO  YES Date: \_\_\_\_\_ Pneumonia  NO  YES Date: \_\_\_\_\_

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**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:

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ARE YOU DIABETIC?  NO  YES INSULIN OR PILLS

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

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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 \_\_\_\_\_