Tomorrow's Face

Associates in Otolaryngology of New Jersey, PA

Patient name: _____

Reason for seeing the doctor today:

_____

_____

_____

Consultation requested by:

_____

Have you had any of the following medical problems?

	Yes	No		Yes	No
*Heart Disease	( )	( )	*High Blood Pressure	( )	( )
*Asthma	( )	( )	*Kidney Disease	( )	( )
*Thyroid Disease	( )	( )	*Arthritis	( )	( )
*Glaucoma	( )	( )	*Jaundice	( )	( )
*Diabetes	( )	( )	*Cancer	( )	( )
*Blood Disease	( )	( )	*Blood clots (legs/lungs)		
*Hay fever or allergies	( )	( )		( )	( )
*Bleed/bruise easily	( )	( )	*Other	( )	( )

Are you currently taking any prescription medications? If so, which ones?

_____

_____

Are you currently taking any over-the-counter medications?

_____

_____

Do you smoke? Yes____ No____ If yes, how much?_____

Do you drink coffee/tea/soft drinks? Yes ____ No ____ If yes, how much? _____
Do you drink alcohol/wine/beer? Yes____ No____ If yes, how much? _____

Have you been hospitalized recently? (If yes, please explain)
_____
_____
_____
_____

Any allergic reactions to medications or anesthesia? Yes____ No____
If yes, please explain:
_____

_____ _____
Patient/guardian signature Date

M.D. initials_____