CRYSTAL COMMUNITY ENT & FACIAL PLASTIC SURGERY
PATIENT HISTORY

TODAY'S DATE: _____

PATIENT NAME: _____ **DATE OF BIRTH:** _____/_____/_____

FAMILY DOCTOR: _____ **DR'S PHONE #** _____

PHARMACY: _____ **PHARMACY PHONE #**_____

ENVIRONMENTAL / FOOD ALLERGIES: _____
_____

FAMILY HISTORY

PROBLEM	RELATIONSHIP*
Diabetes	M F S B
Tuberculosis	M F S B
Hay Fever	M F S B
Asthma	M F S B
Heart Disease	M F S B
High Blood Pressure	M F S B
Hearing Loss	M F S B

*__M__other, __F__ather, __S__ister, __B__rother

ENT SURGERIES

- ☐ Tonsils_____
- ☐ Adenoids _____
- ☐ Ear Surgery/ Mastoid _____
- ☐ Nasal sinus/ Septum/ Polyps _____
- ☐ Skin Cancer of Head & Neck _____
- ☐ Head/ Neck Cancer _____
- ☐ Salivary Gland _____

PLEASE LIST ALL OTHER SURGERIES YOU HAVE HAD SINCE BIRTH:

SURGERY	DATE

PLEASE ANSWER THE FOLLOWING QUESTIONS, IF YES PLEASE EXPLAIN.

Have you ever had **DIFFICULTY** with **ANESTHESIA?** **YES** **NO**
If yes explain _____
Have you ever been diagnosed with a **BLEEDING DISORDER?** **YES** **NO**
If yes explain _____
Are you presently under the care of a **CARDIOLOGIST?** **YES** **NO**
If yes explain _____
Name & Phone number of Cardiologist _____

Do you smoke tobacco products?	YES	NO		
If YES what products do you use?				
Cigarettes			_____# Packs per day	_____Years
Cigars or a Pipe?			_____ Per day	_____ Years
Did you ever smoke and quit?	YES	NO	_____# Years Ago _____ # Packs per day	_____Years
Do you chew tobacco or dip?	YES	NO	_____ Years	Quit, how long? _____
Do you drink alcoholic beverages?	YES	NO	Occasionally _____	Frequently _____
Do you use or have you ever used street drugs?	YES	NO	What? _____	How long? _____
Do you drink caffeine products?	YES	NO	What? _____	# Per day _____

COMMENTS / IMPORTANT FACTS FOR THE DOCTOR: _____
_____

PATIENT HISTORY – OVERALL HEALTH REVIEW

TODAY'S DATE: _____ PATIENT NAME: _____

***Circle ALL diseases that you experience and/or illnesses that you currently have or have had in the past.**

EYES
Blindness
Blurred Vision/Glasses
Cataracts
Double Vision
Glaucoma
Macular degeneration
Retinal disease

EARS
Hearing Aid(s)
Hearing Loss
Infections
Mastoid Cholesteatoma
Pain
Perforation
Ringing (Tinnitus)
Wax

NOSE
Deviated Nasal Septum
Loss of Smell
Nasal Polyps
Nosebleeds
Post Nasal Drip
Runny Nose
Sinusitis
Snoring
Trauma-Broken Nose

MOUTH / THROAT
Cold Sores
Difficulty Swallowing
Dry mouth
Hoarseness/Voice Changes
Loss of Taste
Sleep Apnea
Sore Throat/ Pharyngitis
Stops Breathing at Night
Swollen Glands/Lymph Nodes

RESPIRATORY
Asbestosis
Asthma
COPD
Cough
Coughing up Blood
Cystic fibrosis
Emphysema
History or contact with Tuberculosis
Pneumonia
Pulmonary fibrosis

IMMUNE SYSTEM / ALLERGY
AIDS
Allergic to Bee Stings
Hay fever
Herpes
HIV
Hives
Immunizations up to date
Inhalant Allergies
Lupus

SKIN
Discolored Areas
Easily Bruising
Eczema
Psoriasis
Rash
Skin cancers/growths
Ulcers

ENDOCRINE
Diabetes
Menopause
Parathyroid
Pituitary Gland Problem
Thyroid Disorder

NERVOUS SYSTEM
Alzheimer's/Dementia
Amyotrophic lateral sclerosis (ALS)
Cerebral palsy
Dizziness/Vertigo
Headaches
Loss of consciousness
Multiple Sclerosis (MS)
Myasthenia gravis (MG)
Neuralgia
Numbness
Paralysis
Parkinson's disease
Poor Memory
Seizures
Shingles
Speech Problems
Stroke/CVA/TIA
Tremors/Shakes
Tumor

GASTORINTESTINAL
Abdominal Bleeding
Cirrhosis
Colitis
Diarrhea
Heartburn / Indigestion
Hiatal Hernia
Liver Disease
Ulcers
Vomiting

CARDIOVASCULAR
Abnormal heart rhythm (AFIB)
Cardiovascular disease
Chest Pain/ Angina
Congestive Heart Failure
Coronary artery bypass graft surgery
Heart Attack
Heart Murmur
Heart Surgery/Stents
High Cholesterol
Hypertension (High Blood pressure)
Irregular Heartbeat / Arrhythmia
Mitral Valve Prolapse
Pacemaker

MUSCULOSKELETAL
Arthritis
Disorders of Joints (DJD)
Gout
Grinding of Teeth (Bruxism)
Jaw joint pain / Cracking (TMJD)
Joint Replacement_____
Osteoarthritis
Osteopenia
Osteoporosis
Rheumatoid arthritis
Spinal Disease (Back/Neck)
Weakness

UROLOGY
Gall Bladder
Kidney Disease
Prostate

CANCERS
Bone
Brain
Breast
Cervical
Colon
Leukemia
Liver
Lung
Lymphoma
Prostate/Bladder
Skin
Throat/Oral
Uterine
Chemotherapy
Radiation Therapy
Surgery Therapy

BLOOD
Anemia
Bleeding Disorder
Sickle Cell Anemia
Transfusion
Hepatitis

* History Reviewed by Doctor:

Dr. Initial	Date	Dr. Initial	Date

*** I have completed this form to the best of my ability.**

_____ _____

Patient Signature Date