CEDAR VALLEY
Center for Facial Plastic Surgery
A branch of CVMS
Trust your face to a facial plastic surgeon

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CEDAR VALLEY
ENT and Sinus Center
A branch of CVMS
Advanced ENT and Sinus Solutions

Name:_________________________ **Birthdate:**________________ **Age:**_______
Height:____ **Weight**______

Referred by:______________________ **Primary Physician:**______________________

Reason for appointment:____
____

Allergies: YES NO

Allergy	YES	NO
None known	_____	_____
Penicillin	_____	_____
Sulfa	_____	_____
Local anesthetics	_____	_____
Codeine	_____	_____
IVP Dye	_____	_____
Darvocet	_____	_____
Latex	_____	_____
Other (list):	__________________	

Current Medications (include non-prescription):
____
____
____
____
____
____
____
____

Do you take blood thinners or ASPIRIN daily? ___Yes ___No

Active Problems/Medical History

YES	NO	
___	___	Asthma
___	___	COPD/Emphysema
___	___	High Blood Pressure
___	___	Heart Disease (Angina/CHF/CAD)
___	___	Heart Attack
___	___	Pacemaker / Defibrillator / Irreg. Heartbeat
___	___	Kidney Disease
___	___	Thyroid Problems
___	___	Sleep Apnea
		Sleep study done_____(year)___________(location)
___	___	Hepatitis
___	___	Stroke
___	___	Seizure/Epilepsy
___	___	Diabetes (On insulin / On oral meds)
___	___	Skin Cancer (type______________________)
___	___	Other Cancer (Type______________________)
___	___	Bowel Disease (Diverticulosis/ Crohns)
___	___	Chicken Pox / Measles / Mumps / Rubella
___	___	MRSA
___	___	Head and/or neck mass
___	___	Other:______________________

Previous Surgery:

YES	NO	
___	___	Tonsil/Adenoid Removal
___	___	PE (Ear) Tubes
___	___	Septoplasty / Rhinoplasty
___	___	Hernia
___	___	Sinus Surgery
___	___	C-section
___	___	Colon
___	___	Breast
___	___	Bypass surgery / Stent Placement
___	___	Hysterectomy
___	___	Tubal ligation
___	___	D & C
___	___	Back/Neck
___	___	Appendix Removal
___	___	Skin Cancer Surgery
___	___	Gallbladder Removal
___	___	Other: ___________________

____

Previous Hospitalizations:____
____

OVER

Family History (grandparents, parents, siblings):

YES	NO		RELATIONSHIP
___	___	Lung Disease	______________
___	___	Stroke	______________
___	___	Diabetes	______________
___	___	Tuberculosis	______________
___	___	Cancer Type:______	______________
___	___	Epilepsy	______________
___	___	Heart Disease	______________
___	___	Rheumatoid arthritis	______________
___	___	High Blood Pressure	______________
___	___	Kidney Disease	______________
___	___	Bleeding Tendencies	______________

Social History:

Occupation:

Marital Status:

___Married ___Widowed ___Single ___Divorced

Miscellaneous:

Have you ever had an unusual reaction to general or local anesthetic? ___Yes ___No

Explain______________________________

____

Have you ever had a blood or blood product transfusion? ___Yes ___No

Do you need to take antibiotics before having surgery or dental work done? ___Yes ___No

Do You Smoke? ___**Yes** ___**No**

Use Smokeless Tobacco? ___**Yes** ___**No**

Ever smoked/used tobacco? ___**Yes** ___**No**

Exposed to second-hand smoke? ___**Yes** ___**No**

Alcohol? ___Yes ___ No Amount __________

Caffeine? ___Yes ___No Amount__________

Review of Systems: Signs and / or symptoms you may have experienced recently.

YES	NO		YES	NO		YES	NO	
___	___	Unexplained Weight Gain	___	___	Stuffy Nose	___	___	Heartburn/indigestion
___	___	Unexplained Weight Loss	___	___	Bloody Noses	___	___	Anxiety/nervousness
___	___	Fever / Chills	___	___	Sinus Headaches	___	___	Rashes
___	___	Ear Pain	___	___	Runny nose	___	___	Changing skin lesions
___	___	New Hearing Loss	___	___	Post Nasal Drip	___	___	Shortness of Breath
___	___	Ringing in Ears	___	___	Snoring	___	___	Coughing Up Blood
___	___	Itching in Ears	___	___	Sore Throats	___	___	Chronic Cough
___	___	New Visual Changes	___	___	Difficulty Swallowing	___	___	Difficulty Urinating
___	___	Dry Eyes	___	___	Hoarseness	___	___	Other__________
___	___	Joint pain	___	___	Swollen lymph nodes			
___	___	Heart Palpitations						

Patient Signature________________________________ **Date**______________

Physician Signature________________________________ **Date**______________

__________ __________ __________ __________

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