# The Center for Aesthetic Facial Surgery Medical History Form

Patient Name_____Today's date_____

*Please answer this questionnaire to the best of your knowledge. The information is confidential and will be used by the staff of Advanced Ear, Nose and Throat for evaluation and treatment.*

1. MEDICATIONS
   List all your current over the counter and prescription medications:_____

   _____

2. ALLERGIES
   Are you allergic to any medications, foods or latex? _____

3. SOCIAL *(Please circle your response)*

   Do you drink alcoholic beverages? Yes No Occasional Moderate Heavy

   Do you use tobacco? Yes No Never smoked Previous smoker Chew
   Smoke < 1 pack/day Smoke 1-2 pack/day Smoke 2-3 pack/day

   Do you use any recreational drugs? Yes No

4. SURGERIES: Please list any ear, nose and throat surgeries and any other major surgeries/hospitalizations in your lifetime. _____

   _____

5. ILLNESSES OR CONDITION: Are you under the care of a doctor for a specific illness/condition or have you been treated in the past for: *(Please check your response)*

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Allergies | ( ) | ( ) | Kidney/Bladder | ( ) | ( ) |
| Anemia | ( ) | ( ) | Lungs | ( ) | ( ) |
| Asthma | ( ) | ( ) | Meningitis | ( ) | ( ) |
| Autoimmune disease | ( ) | ( ) | Migraine Headaches | ( ) | ( ) |
| Bleeding disorders | ( ) | ( ) | Mitral Valve Prolapse | ( ) | ( ) |
| Bone or joint | ( ) | ( ) | Nasal Trauma | ( ) | ( ) |
| Cancer | ( ) | ( ) | Nervous System | ( ) | ( ) |
| Chemical Dependency | ( ) | ( ) | Nosebleeds | ( ) | ( ) |
| COPD | ( ) | ( ) | Reflux/GERD/heartburn | ( ) | ( ) |
| Diabetes | ( ) | ( ) | Seizure Disorder | ( ) | ( ) |
| Hearing Loss | ( ) | ( ) | Sinusitis | ( ) | ( ) |
| Heart | ( ) | ( ) | Sleep Apnea | ( ) | ( ) |
| Hepatitis | ( ) | ( ) | Stomach or Bowels | ( ) | ( ) |
| HIV | ( ) | ( ) | Thyroid | ( ) | ( ) |
| High Cholesterol | ( ) | ( ) | Tinnitus/Ringing in the ears | ( ) | ( ) |
| Hypertension | ( ) | ( ) | Tuberculosis | ( ) | ( ) |
| Hypotension | ( ) | ( ) | | | |

6. FAMILY HISTORY:

| | | | | | |
|---|---|---|---|---|---|
| Allergies | ( ) | ( ) | Premature Hearing Loss | ( ) | ( ) |
| Asthma | ( ) | ( ) | Sinusitis | ( ) | ( ) |
| Autoimmune Disease | ( ) | ( ) | Sleep Apnea | ( ) | ( ) |
| ENT related cancers | ( ) | ( ) | Thyroid Disorders | ( ) | ( ) |
| Migraine Headaches | ( ) | ( ) | | | |