PLEASE PRINT CLEARLY
PRESENT YOUR HEALTH CARD TO THE SECRETARY

NAME_____DATE OF BIRTH_____.

YOUR OCCUPATION_____ AGE:

REFERRING PHYSICIAN_____. EMAIL ADDRESS:

TODAY'S **PRIMARY** COMPLAINT (CHOOSE ONE)

SNORING ☐ EARS ☐ NOSE ☐ THROAT ☐ DIZZINESS ☐ NECK MASS ☐

OTHER☐ (SPECIFY)_____.

DO YOU HAVE:	HIGH BLOOD PRESSURE	YES☐ NO☐	ASTHMA	YES ☐ NO☐
	DIABETES	YES ☐ NO☐	BRONCHITIS	YES ☐ NO☐
	HEART MURMUR	YES ☐ NO ☐	THYROID DISEASE	YES ☐ NO☐
	HEART FAILURE	YES ☐ NO ☐	ARTHRITIS	YES ☐ NO☐
	IRREGULAR HEART BEAT	YES ☐ NO☐	BLEEDING PROBLEMS	YES☐ NO☐
	HEART VALVE SURGERY	YES ☐ NO☐	SLEEP APNEA	YES ☐ NO☐
	KIDNEY DISEASE	YES ☐ NO☐	EPILEPSY	YES ☐ NO☐

OTHER MEDICAL PROBLEMS (STATE)_____.

HAVE YOU HAD A GENERAL ANESTHETIC ? YES☐ NO☐

HAVE YOU HAD AN ADVERSE REACTION TO A GENERAL ANESTHETIC? YES☐ NO☐

HAVE YOU HAD:	TONSILLECTOMY	YES ☐ NO☐	PALATE SURGERY	YES☐ NO☐
	NASAL SURGERY	YES ☐ NO☐	EAR SURGERY	YES ☐ NO☐
	SINUS SURGERY	YES☐ NO☐	LARYNGEAL SURGERY	YES ☐ NO☐

OTHER SURGERY (SPECIFY)_____.

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:_____, _____, _____,
(INCLUDING HERBAL MEDICATIONS)

_____, _____, _____,

DO YOU SMOKE? NO☐ YES☐ HOW MUCH?____PACKS PER DAY FOR____YEARS QUIT ☐

DO YOU DRINK ALCOHOL? DAILY ☐ ALMOST DAILY ☐ OCCASIONALLY☐ NEVER☐

DO YOU HAVE ANY ALLERGIES? NO☐ YES☐ (SPECIFY)_____.

HAVE YOU HAD ANY ADVERSE REACTIONS TO MEDICATIONS? NO☐ YES ☐ (SPECIFY)_____..

It is our practice to call patients or send an email with results that are felt to be benign in nature and which do not require further follow up. At times this may result in this information being left on your answering machine or in your email. Please check the box to indicate whether this is acceptable to you and initial below. If you do not wish to have a message of this nature left on your machine it will be left to you to contact the office or your family physician to determine the results of any tests or biopsies done in this office which are not felt to require any further follow up. ☐YES THIS IS ACCEPTABLE ☐ NO THIS IS NOT ACCEPTABLE

Signature:_____.