Dr. Michael Freedman

Ear, Nose, Throat, Allergies & Facial Plastic Surgery

Patient Name____________________

Age ________ Height _________ Weight _________ Sex: M F Marital Status: S M D W L/W

If female, are or could you be **pregnant**? Y N Number of pregnancies ________

Allergies to Medications (If none, please indicate by writing NONE. List medication-reaction) ____________________

Current **Prescription Medications**____

Herbal / Vitamins ____

History of **bleeding disorders** in you or your family? Yes No History of **transfusions**? Yes No

Current Medical Problems: Check ☑ any or all that apply, if not recent note approximate year beside item.

☐ Tuberculosis	☐ Emphysema	☐ Pneumonia	☐ Hay Fever	☐ Asthma	☐ Arthritis
☐ High Blood Pressure	☐ Low Blood Pressure	☐ Irregular Heart Beat	☐ Chest Pain	☐ Heart Attack	☐ Heart Failure
☐ Irritable Bowel/Colitis	☐ Stomach Ulcers	☐ Thyroid Condition	☐ Diabetes	☐ Obesity	☐ Stroke
☐ Prostate Problems	☐ Kidney Failure	☐ Blood Disorders	☐ Anemia	☐ Migraines	☐ Seizures
☐ Mononucleosis	☐ Mitral Valve Prolapse	☐ HIV/AIDS	☐ Sleep Apnea		

☐ Recurrent Infections, where? ______________ ☐ Cancer, where? ____________________________

Medical conditions not listed? ______________________________________

Surgeries: Check ☑ any surgeries you have had, note approximate year (if known) beside item.

Location of Surgery	**Specific Type of Surgery**			
Ear Surgery	☐ Tubes	☐ Mastoidectomy	☐ Stapedectomy	☐ Ear-Unsure
Nose Surgery	☐ Septum	☐ Rhinoplasty	☐ Sinus Surgery	☐ Nose-Unsure
Throat Surgery	☐ Tonsils	☐ Throat Cancer	☐ Wisdom Teeth	☐ Throat-Unsure
Neck Surgery	☐ Lymph Node	☐ Thyroidectomy	☐ Thyroglossal Duct Cyst	☐ Neck-Unsure
Breast/Lung Surgery	☐ Biopsy	☐ Mastectomy	☐ Bronchoscopy	☐ Lung-Lobectomy
Heart Surgery	☐ Bypass	☐ Angioplasty	☐ Valve Replacement	☐ Heart-Unsure
Abdomen Surgery	☐ Gallbladder	☐ Appendectomy	☐ Bowel Resection	☐ Splenectomy
Female Surgery	☐ D & C	☐ Hysterectomy	☐ Tubal Ligation	☐ C-Section
Eye Surgery	☐ Cataract	☐ Radial Keratonomy	☐ Laser	☐ Eye-Unsure
Other Surgery	☐ Hemorrhoidectomy	☐ Skin Cancer	☐ Hernia	☐ Hip Fracture

Surgery not listed ______________________________________

Complications of surgeries ______________________________________

Parents health (if deceased, cause of death) ________________________________

Check ☑ all that apply to your **immediate family** (Parents, Siblings):

☐ Ear Surgery	☐ Early Hearing Loss	☐ Hay Fever	☐ Asthma	☐ Bleeding Disorders
☐ Diabetes	☐ High Blood Pressure	☐ Cancer	☐ Stroke	☐ Heart Problems

Social History: ***(Special note: Dr. Freedman is not judgmental regarding your habits, this information is essential to treating you and you can be assured it will NOT leave the chart---Please answer honestly)***

Tobacco use: Did you ever smoke cigarettes in your lifetime? Y N How much? Packs per day? _____ Years? ______

When did you quit smoking? _____ years ago. Do you use any other type of tobacco? ☐ pipe ☐ snuff

Alcohol use: Y N If yes, how often? ☐ rare ☐ monthly ☐ weekly ☐ daily How much? _________

Caffeine use: Y N ☐ Coffee ☐ Tea ☐ Pop Which one(s) and how much?________________________

Recreational drug use: Y N If yes, what type and amount? ______________________________

Sexual history: Any history of sexually transmitted diseases? Y N Have you been tested for **HIV**? Y N

Currently **working**? Y N Job Title: ______________________________ Exposure to **chemicals**? __________

Exposure to **noise** at work? _________________________ Do you wear **hearing protection**? _______________

If not currently working, are you on **disability**? Y N What type of injury? ___________________________

I certify that the history form is filled out completely and accurately. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature____ Date __________________

I have reviewed the information on the two pages of the Introductory Data Sheet with the patient.

Michael A. Freedman, D.O. ____ Date __________________