

CINCINNATI HEAD AND NECK, Inc.

New Patient Medical History

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Today's Date: ____ / ____ / ____ Date of Birth: ____ / ____ / ____

Your Name: _____ Age: _____ Occupation: _____

Medication Allergies: NO YES (List) 1. _____ 2. _____ 3. _____ 4. _____

Current Medications: Please list your present medications: (Prescription, Over-the-counter, Vitamins and Supplements:

1) _____ 4) _____ 7) _____
2) _____ 5) _____ 8) _____
3) _____ 6) _____ 9) _____

Smoking: Never _____ Yes _____ # _____ Packs per day for _____ years. Quit in _____ (year)

Alcohol: Never _____ Yes _____ # _____ Drinks per day.

Past Medical History: Do you have or have you ever had the following?

- Diabetes**
Yes No
If Yes: Do you take Insulin: Yes ____ No ____ How long have you been diabetic (Years): _____
- Asthma**
Yes No
If Yes: Have you ever required steroids? _____ Do you use inhalers? _____
- Ulcers**
Yes No
If Yes: Circle type: Stomach Duodenal Can you take Aspirin, Motrin, Advil or other anti-inflammatories?: Yes No
- Liver Disease**
Yes No
If Yes: Circle type Hepatitis B Hepatitis C Cirrhosis Other: Is it presently active?: Yes No
- Kidney Disease**
Yes No
If Yes: Problem: _____ Are you under dialysis?: Yes No Have you had a transplant?: Yes No
- Bleeding Disorder**
Yes No
If Yes: Are you on blood thinners?: Yes No Type of bleeding problem _____
- Infectious Disease (Mono, Tuberculosis, Hepatitis, HIV/AIDS, Other?)**
Yes No
If Yes: What disease?: _____ Year diagnosed: _____ Are you presently under treatment?: Yes No
- Immune System Disorder**
Yes No
If Yes: Circle type Rheumatoid Arthritis Lupus (SLE) Psoriasis Immunosuppressive Drugs Other
- Heart Disease**
Yes No
If Yes: Please circle: Cardiac Bypass Pacemaker Valve Replacement Heart Failure
Do you require antibiotic coverage for procedures? Yes ____ No ____
- Cancer**
Yes No
If Yes: Type of Cancer: _____
Date Treated (Year): _____ Treated with (Circle all that apply): Surgery Radiation Chemotherapy
- High Blood Pressure**
Yes No

Past Surgeries:

1) _____ 2) _____ 3) _____

Continue on Next Page. Leave this space blank:

Both sides reviewed by Physician (sign) _____

Family History Please check if you have any known blood relatives with the following:

- Auto-Immune Disease (Rheumatoid/Lupus/Etc): If Yes: Type: _____ Relationship: _____
- Blood or Bleeding Disorder: Type: _____ Relationship: _____
- Nerve Disease: If Yes: Type: _____ Relationship: _____
- Muscle Disease: If Yes: Type: _____ Relationship: _____
- Bone Disease: If Yes: Type: _____ Relationship: _____
- Trouble with General Anesthesia: Type: _____ Relationship: _____
- Cancer: If Yes: Type: _____ Relationship: _____

Allergy Testing: Have you been allergy tested? _____ Sensitive to (list): _____ , _____ , _____ , _____ .
Did you receive allergy shots? _____ Dates? _____ Where? _____
Pets: _____

Review of Symptoms: Please check any that apply.

Constitutional:

- Fever
- Chills
- Weight Change

Eyes:

- Blindness
- Double Vision / Blurred Vision
- Burning

Cardiovascular:

- Chest Pain
- Palpatations
- Irregular Heart Beats
- Ankle Edema or Swelling

Musculoskeletal:

- Joint Swelling
- Gout
- Muscle Aches

Neurological:

- Weakness
- Loss of Coordination
- Dizziness
- Headaches
- Seizures
- Tremors
- Stroke

Respiratory:

- Cough
- Shortness of Breath
- Cough with Blood

Urinary:

- Prostate enlargement
- Obstruction from meds

Gastrointestinal:

- Abdominal Pain
- Bloating
- Constipation
- Diarrhea
- Heartburn or Reflux

Skin:

- Rash
- Skin Cancer
- Itching
- Change in Moles

Immunological:

- Food Sensitivity
- Asthma
- Recent Vaccinations

Emotional:

- Trouble Sleeping
- Anxiety
- Trouble Concentrating
- Mood Swings

Endocrine:

- Weakness
- Heat or Cold Intolerance
- Increased Thirst
- Frequent Urination
- Hair Loss

Hematological:

- Bleeding
- Bruising
- Enlarged Lymph Nodes
- Anemia

General:

- Recent Travel Abroad
- Work exposures

Form Completed by: _____