Ear, Nose, & Throat Surgery Center

Patient Label

Medical Screening/History
Page 1

Please take a few minutes and complete this form. This information will help us to provide effective and safe surgical care to you or your family member.

Patient Information		
Name:	Date of Birth:	Age:
	Marital Status:	Gender:
Weight:	Ht: __(Ft) _____)Inches)	
Planned Date of Surgery:	Surgeon:	

Personal History: (If yes please describe the type and amount used)
Tobacco Use: Yes___ No____ Describe:
Alcohol Use: Yes____ No____ Describe:
Recreational Drugs: Yes____ No____ Describe:
Do you have a family doctor: Yes___ No___ If yes Doctor's Name:
When was the last time you saw your doctor? Date: Reason:

Medical History: (If yes to testing for this surgery indicate where it was done please)
Current Medications: Please list:
Allergies:
Have you had any of the following tests for this surgery?
Chest x-ray: No____ Yes_____ Where?
MRI/CT: No____ Yes_____ Where?
Blood Test: No____ Yes_____ Where?
Mammogram: No____ Yes_____ Where?
EKG: No____ Yes_____ Where?
Please List Past Surgery:
Past History:

Have you or any blood relative ever had the following:
Problems with Anesthesia: No_____ Yes_____ Explain:
Diagnosed with Malignant Hyperthermia: No____ Yes_____
Been Diagnosed with Psudocholinesterase Deficiency: No ____ Yes____
Blood Relative had problems with Anesthesia: No ____ Yes____ Explain:
Females: Do you have any children? No ____ Yes____ How many?_____ Natural Birth #_____ C-section #_____

Thank you for taking the time to complete these questions. We know that you might have been asked these questions before and might be asked again. It is not that we don't talk to one another it is to assure your safety. On the day of surgery please expect to be asked often your name, date of birth and the type of surgery you are going to have and to confirm the right or left side if appropriate. Again your safety is our primary goal.

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Please complete and bring with you on your day of surgery the Nurse may call you before surgery
and ask these questions.

History of:	Yes	No	Explain	History	Yes	No	Explain
High/Low Blood Pressure				Pins or Metal Implants			
Shortness of Breath/Chest Pains				Pins & Needles Sensation			
Do you have a pacemaker				Numbness Tingling			
Heart Attack				Weakness in Extremity			
Stroke/TIA				Hernia			
Fainting/Dizziness				Joint Replacements			
Blood Clots/Emboli				Osteoporosis			
Pneumonia				Head Injuries			
Asthma/Bronchitis Emphysema				Neck Injury/Surgery			
Rheumatic Fever				Shoulder Injury/ Surgery			
Diabetes				Elbow or Hand Injury/ Surgery			
Hypoglycemia				Back Injury/Surgery			
Thyroid/ Dysfunction/ Goiter				Knee Injury/Surgery			
Did the patient complete this survey				Leg/Ankle/Foot Injury/Surgery			
Epilepsy/Seizure				Sever or Frequent Headaches			
Hepatitis/Jaundice				Loose, False, Capped Teeth			
Gastric Disorder				Contact Lenses			
Bleeding/Bruising Problems				Hearing Aid			

Anemia				Sleeping Difficulties			
Sickle Cell Disease				Emotional/ Psychological Difficulties			
Cancer Chemo or Radiation				Bowel or Bladder Difficulties			
Arthritis/Swollen Joints				Weight loss/Weight Gain			
Varicose Veins				Are You pregnant			
				Date of Last Period (females only)			