Nancy Dr. BECKER
EARS, NOSE & THROAT ◊ ALLERGY THERAPY ◊ FACIAL PLASTIC SURGERY
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History & System Review (2 pages)

Patient Name _____
Last First Middle

Age _____ ***Weight*** _____ ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Male ☐ Female

If female, are you or could you be pregnant? ☐ No ☐ Yes ***Number of pregnancies*** _____

Surgeries/year _____/_____ _____/_____

Surgeries/year _____/_____ _____/_____

Surgeries/year _____/_____ _____/_____

Complications of surgery _____

Current medical problems _____

Current medications _____

Allergies / Reactions _____

Alcohol use ☐ No ☐ Yes If yes, amount_____ ***Caffeine use*** ☐ No ☐ Yes If yes, amount _____

Tobacco use ☐ No ☐ Yes If yes, type/amount _____

Past tobacco use ☐ No ☐ Yes If yes, type/amount _____ Quit when? _____

Passive (second hand) smoke exposure ☐ No ☐ Yes If yes, frequency _____

Recreational drug use ☐ No ☐ Yes If yes, type/amount _____ ☐ Prefer to discuss with physician

Currently working ☐ No ☐ Yes ***Job title*** _____

Father's health (if deceased, cause of death) _____

Mother's health (if deceased, cause of death) _____

Siblings with significant medical problems ☐ No ☐ Yes _____

Check all that apply to your immediate family: parents/grandparents/siblings

☐ diabetes ☐ asthma ☐ high blood pressure ☐ stroke ☐ bleeding disorders ☐ heart problems

☐ cancer _____ ☐ ear surgery ☐ early hearing loss ☐ hayfever

I certify that this 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 above information with the patient.

STAFF SIGNATURE _____ **DATE** _____