

If you have any questions please call us at
(972) 296-1587

Name: _____ Date: _____

Do you currently take any drugs or medications? _____ Yes _____ No

If yes, please list

(include any aspirin products, Motrin, Advil, Tylenol, herbal supplements, recreational drugs, arthritis medications)

Are you allergic to any medications? _____ Yes _____ No

If yes, please list (include medication and reaction)

Have you ever had: (Please check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Stroke | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Keloid Scarring |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Bleeding Problems |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Strep Throat | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Migraine Headache | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Radiation |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Trauma to Face/Head |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Back Problems | <input type="checkbox"/> TMJ Problems |
| <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Steroid Use |
| <input type="checkbox"/> Frequent Heartburn | <input type="checkbox"/> Loose/Chipped Teeth | <input type="checkbox"/> Accutane Treatment |

Do you have: (Please check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Ear Pain | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Draining Ears | <input type="checkbox"/> Frequent "colds" | <input type="checkbox"/> Sore Throat/Strep Throat |
| <input type="checkbox"/> Ear Wax | <input type="checkbox"/> Snoring | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Decreased Hearing | <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Laryngitis |
| <input type="checkbox"/> "Noise" in Ears | <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Jaw Joint Pain | |

Tobacco Use: ___ Yes ___ No Amount: _____ How many years: _____ Last use: _____

Alcohol Use: ___ Yes ___ No Amount: _____ How often: _____ Last use: _____

Could you be pregnant? ___ Yes ___ No Date of last menstrual period: _____

List all previous surgeries and approximate year: _____

Any problems with previous anesthesia or surgery: _____ Yes _____ No

If yes, please describe: _____

Family history or problems with anesthesia such as high fever or cardiac arrest? _____ Yes _____ No

If yes, please describe: _____

List any disabilities: _____

List any other ongoing medical problems: _____

Do any family members have (please check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Kidney Disease | | |

I have fully reviewed this questionnaire and answered all questions truthfully and to the best of my knowledge.

Signature of Patient, Parent of Guardian: _____