ENT & PLASTIC SURGERY
Specialists of Louisiana

Patient: _____
please print name

Primary Care Physician: _____ **Pharmacy:** _____

Reason for today's visit: _____

List daily medications and dosage: _____

_____

_____

Drug Allergies? _____

Prior surgeries: _____

_____

MEDICAL HISTORY

Patient - please check the appropriate boxes below for any conditions you are *currently* experiencing.

		FAMILY HISTORY	
Condition	**Patient**	**Mother**	**Father**
Allergic rhinitis			
Anxiety			
Asthma			
Heart Condition*			
Lung Disease*			
Diabetes			
Hearing Loss			
Heartburn / Reflux			
High Blood Pressure			
Sleep Apnea			
Snoring			
Kidney Failure			
Sinusitis			
Stroke			
Smoking			
Anemia			
Depression			
Heart Attack			
Hypothyroidism			
Migraine			
Cancer*			
Other			

**specify condition* Family history unknown

Previous Radiation
☐ Yes ☐ No

Prior Chemotherapy
☐ Yes ☐ No

Smoking Status
☐ Never

Current Smoker
☐ Yes ☐ No
Number of cigarettes/day: _____
How many years? _____

Former Smoker
☐ Yes ☐ No
Number of cigarettes / day: _____
How many years? _____
Quit Date: _____

Do you drink alcohol?
☐ Yes ☐ No
☐ Beer ☐ Wine ☐ Liquor
Number of drinks: _____
☐ daily ☐ weekly ☐ monthly ☐ yearly

Have you ever used illegal or IV drugs?
☐ Yes ☐ No
Type: _____