MANI H. ZADEH M.D., F.A.C.S.
HEAD & NECK SURGERY | EAR, NOSE & THROAT

Patient's Name: _____ **Date of Visit:** ___/__/___

Reason for Visit: _____

Current Medicines: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____

Allergies to Medicines: 1. _____ 2. _____ 3. _____ 4. _____

Please list all prior major illnesses/surgeries (with years):

Illnesses/Injuries: 1. _____ 2. _____ 3. _____

Hospitalizations: 1. _____ 2. _____ 3. _____

Operations: 1. _____ 2. _____ 3. _____

Family History (check)? __ Heart disease __ Diabetes __ Cancer __ Other _____

Which family member? _____

Do you drink soda/coffee/tea? __ No, never __ No, but I used to __ Yes Cups/Drinks per day? ____

Do you drink alcohol? __ No, never __ No, but I used to __ Yes How many drinks?___/day or wk

Do you smoke? __ No, never __ No, but I used to __ Yes Packs per day? ___x ___ years

Do you use illicit drugs? __ No, never __ No, but I used to __ Yes Which? _____

Have you experienced any of the following? (circle Y or N)

Constitutional
- weight gain/loss(>15lbs) Y N
- constant night sweats Y N

Eyes
- double vision Y N
- glaucoma Y N

Ear/Nose/Throat
- hearing loss Y N
- ear pain Y N
- ringing in ears Y N
- balance problems Y N
- hearing aid Y N
- difficulty breathing Y N
- nosebleeds Y N
- nasal drainage Y N
- sinus problems Y N
- snoring Y N
- voice changes Y N

Cardiovascular
- heart attack Y N
- High blood pressure Y N
- heart murmur Y N

Gastrointestinal
- diarrhea Y N
- heartburn Y N

Endocrine
- diabetes Y N
- thyroid disease Y N
- autoimmune disease Y N

Neurologic
- headaches Y N
- seizures Y N
- stroke Y N

Hematology
- bruise easily Y N
- anemia Y N

Genitourinary
- frequent urination Y N
- prostate problems n/a Y N

Skin
- past skin cancer Y N
- past radiation therapy Y N

Musculoskeletal
- arthritis Y N
- back pain Y N

Respiratory
- asthma/emphysema Y N
- chronic cough Y N
- Tuberculosis Y N

Psychiatric
- anxiety Y N
- depression Y N
- sleep problems Y N

Other

If Yes to any of the above, please explain: _____

_____

Reviewed by: _____M.D.