DR. PAUL ROSSOS, M.D.
DIPLOMATE OF AMERICAN BOARD OF OTOLARYNGOLOGY
OTOLARYNGOLOGY – HEAD AND NECK SURGERY
FACIAL PLASTIC SURGERY

PATIENT'S NAME: _____ **DATE:** _____

HISTORY AND PHYSICAL INFORMATION

ONGOING MEDICAL PROBLEMS & PLEASE CHECK ALL THAT APPLY:

HYPERTENSION__	ASTHMA__	ACID REFLUX__
DIABETES__	HYPOTHYROIDISM__	HEART DISEASE__
COPD__	HYPERTHYROIDISM__	HIGH CHOLESTEROL__

CANCER (TYPE):_____ Other:_____

PLEASE LIST ANY SURGERIES & PAST MEDICAL PROBLEMS:

_____

_____

PLEASE LIST ANY MEDICATIONS TAKEN ON A REGULAR BASIS:(OR PROVIDE LIST)

MEDICATION	DOSAGE	FREQUENCY	REASON

ARE YOU ALLERGIC TO ANY MEDICATION? YES NO

IF YES LIST NAMES AND EXPLAIN THE TYPE OF REACTION OR EXPLAIN THE SYMPTOMS:

_____

_____

_____

FAMILY MEDICAL HISTORY (Mother, Father, Grandparents):

HEARING LOSS	_____
HEAD & NECK	_____
CANCER	_____
DIABETES	_____
HIGH BLOOD PRESSURE	_____
HEART DISEASE	_____
STROKE	_____
LUNG CONDITIONS	_____

OTHER:_____

DO NOT WRITE IN THIS SPACE:

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Patient's Name: _____ **Date:** _____

HEIGHT _____ **WEIGHT** _____

WHY ARE YOU HERE TODAY? _____

_____

WHAT SYMPTOMS DO YOU HAVE? (CHECK ALL THAT APPLY)

EARACHES	_____	SORE THROAT	_____
DIZZINESS	_____	HOARSENESS	_____
HEARING LOSS	_____	LARYNGITIS	_____
RINGING IN EARS	_____	FEVER	_____
ITCHING EARS	_____	SPITTING BLOOD	_____
DISCHARGE IN EARS	_____	SNORING	_____
DIFFICULTY BREATHING	_____	LUMPS	_____
NOSEBLEEDS	_____	HEARTBURN	_____
DIFFICULTY SWALLOWING	_____	BURPING	_____
TIREDNESS	_____	DOUBLE VISION	_____
CHILLS	_____	HEADACHES	_____
SNEEZING:	_____	COUGH	_____
STUFFY NOSE/CONGESTION:	_____	WAX	_____
RUNNY NOSE:	_____	OTHER SYMPTOMS:	
POSTNASAL DRAINAGE	_____	_____	
ITCHY EYES/NOSE	_____	_____	

DO YOU SMOKE? YES___ NO___ PACKS PER DAY____
WERE YOU A PREVIOUS SMOKER? YES___ NO___

DO YOU DRINK ALCOHOL? YES___NO___ DAILY___ SOCIALLY___

DO YOU DRINK COFFEE? YES___ NO ____ CUPS PER DAY___

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