

OTOLARYNGOLOGY — HEAD AND NECK SURGERY

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NEW PATIENT FORM

Please complete this form prior to seeing the physician. **PLEASE PRINT**

Date of Visit: ___/___/___

Patient Name: _____

Date of Birth: ___/___/___

Please circle: Miss / Ms. / Mrs. / Mr. / Dr. / Rev.

Phone: (home) (___) _____ (work) (___) _____ (emergency) (___) _____

Referring Physician:

Primary Care Physician:

Name _____

Name _____

Street _____

Street _____

City/St/Zip _____

City/St/Zip _____

What is the main reason you are here today to see the doctor? _____

PAST MEDICAL HISTORY: Have you ever had any of the following medical conditions?

Bleeding Problems: <input type="checkbox"/> NONE <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Deep Vein Thrombosis/Blood Clots Other: _____	Skin: <input type="checkbox"/> NONE <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis Other: _____
Cancer: <input type="checkbox"/> NONE <input type="checkbox"/> Breast <input type="checkbox"/> Oral Cavity <input type="checkbox"/> Colon <input type="checkbox"/> Prostate <input type="checkbox"/> Leukemia <input type="checkbox"/> Renal/Kidney <input type="checkbox"/> Lung <input type="checkbox"/> Skin <input type="checkbox"/> Lymphoma <input type="checkbox"/> Throat <input type="checkbox"/> Metastatic <input type="checkbox"/> Thyroid <input type="checkbox"/> Nasal Cavity Other: _____	Neurologic Problems: <input type="checkbox"/> NONE <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Depression <input type="checkbox"/> Drug/Alcohol Dependency <input type="checkbox"/> Seizures <input type="checkbox"/> Sleep Disorder <input type="checkbox"/> Stroke Other: _____
Endocrine/Metabolism: <input type="checkbox"/> NONE <input type="checkbox"/> Diabetes <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Hypothyroidism Other: _____	Allergy/Rheumatology: <input type="checkbox"/> NONE <input type="checkbox"/> Arthritis <input type="checkbox"/> Connective Tissue Disease <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Sjogren's Syndrome Other: _____
Digestive: <input type="checkbox"/> NONE <input type="checkbox"/> Colitis <input type="checkbox"/> Gallstones <input type="checkbox"/> Gastric Reflux <input type="checkbox"/> Hepatitis <input type="checkbox"/> Peptic ulcers Other: _____	Lung: <input type="checkbox"/> NONE <input type="checkbox"/> Asthma <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Emphysema <input type="checkbox"/> Sarcoidosis Other: _____
Heart Disease: <input type="checkbox"/> NONE <input type="checkbox"/> Angina/Chest Pain <input type="checkbox"/> Heart Failure <input type="checkbox"/> Arrhythmias <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart Attack <input type="checkbox"/> Peripheral vascular disease Other: _____	Urinary: <input type="checkbox"/> NONE <input type="checkbox"/> Bladder Infections <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Kidney Stones Other: _____
Infectious Disease: <input type="checkbox"/> NONE <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Tuberculosis Other: _____	Other Medical Problems: <input type="checkbox"/> NONE (if yes, please list) _____

PAST SURGICAL HISTORY: Please list any surgeries you have had (include dates if possible)

Occupation now or before retirement? _____

Have you ever used tobacco? NO YES (If Yes, please check the appropriate spaces.)

- Cigarettes? – How many packs per day? _____ How long? _____ Quit? _____ When? _____
- Cigars/Pipe?
- Chew tobacco?
- Used snuff?

Did you ever drink alcohol? NO

Yes ____ Socially? _____ More than socially? _____ Quantity? _____ Quit? (When?) _____

Family Medical History: What were the major medical problems, if any, of your parents, grandparents, siblings? (Mark all that apply.)

- Cancer (What kind?) _____
- Heart Disease
- Diabetes
- Thyroid
- Other (what?) _____

ALLERGIES: NONE (If Yes, please list)

- Drugs? _____
- Foods? _____
- Seasonal? _____

CURRENT MEDICATIONS: NONE

(Please give names, dosages, and frequency of any medications you are taking.)

- Antibiotics _____
- Anxiety (i.e., Valium, Prozac, etc.) _____
- Aspirin _____
- Blood Thinner (i.e. Coumadin) _____
- Heart Pills _____
- Blood Pressure _____
- Diabetes (i.e., Insulin) _____
- Allergy/Sinus _____
- Pain _____
- Sleeping _____
- Steroids _____
- Stomach/Ulcer (i.e., Prilosec, Zantac, etc.) _____
- Other: _____

CURRENT PROBLEMS: (Please mark all appropriate responses to the following.)

CONSTITUTIONAL: NONE

- Weakness
- Fever
- Weight Loss
- Weight Gain

SKIN NONE

- Lumps
- Rash
- Itching
- Lesions

EYES: **NONE**

- Itching
- Excess Tearing
- Change in Vision
- Double Vision

Other: _____

EARS: **NONE**

- Pain
- Swelling
- Discharge
- Loss of hearing
- Ringing/Buzzing
- Dizziness/Imbalance

Other: _____

NOSE: **NONE**

- Obstruction
- Discharge
- Bleeding
- Loss of smell

Other: _____

MOUTH/THROAT: **NONE**

- Sores/Ulcers
- Throat Pain
- Difficulty swallowing
- Voice Changes

Other: _____

NECK: **NONE**

- Stiffness
- Lumps/Swelling
- Pain

Other: _____

HEART/LUNGS: **NONE**

- Chest Pain
- Palpitations
- Shortness of breath
- Cough

Other: _____

DIGESTIVE/URINARY: **NONE**

- Heartburn/Indigestion
- Nausea/Vomiting
- Constipation
- Diarrhea
- Burning with Urination
- Urinary incontinence
- Urinary retention

Other: _____

NERVOUS/VASCULAR: **NONE**

- Headache
- Numbness
- Tremor

Other: _____

This information has been reviewed with the patient. Follow-up information will be forwarded to your physician in a timely manner.

Patient Signature: _____

Physician Signature: _____