ALASKA FACIAL PLASTIC SURGERY & ENT

PATIENT MEDICAL HISTORY FORM

Patient Name:_____ **Age:**_____ **Date of Birth:**_____ **Sex:**_____

Primary Language:_____ **Ethicity**:_____

Phone:_____ **Email**:_____

Mailing Address:_____

Contact Preference: ☐ Text ☐ Call ☐ Email Detailed message? ☐ Yes ☐ No

Emergency Contact:_____ Relationship:_____ Phone Number:_____

Marital Status: ☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Primary Care Physician:_____ **Pharmacy**:_____
(Include Pharmacy Name and Location)

Insurance Plan:_____

Policy Holder Name: _____ **DOB:**_____ **Relationship to Patient:**_____

Patient resides primarily with:_____

Legal Guardian:_____ Relationship:_____ Phone Number:_____

Do you have any advanced directives on file with a hospital or provider? ☐ Yes ☐ No

NATURE OF VISIT:

~ Chief Complaint (Reason for today's visit):_____

Do you currently take ANY medications: ☐ Yes ☐ No If Yes, list **Name of Medication**, **Dosage** and **Frequency**:

Name of Medication	Dosage	Frequency	Name of Medication	Dosage	Frequency

Drug Allergies: ☐ Yes ☐ No If Yes, list **Name of Drug** and **Reaction**:

Name of Drug	Reaction

Latex Allergy: ☐ Yes ☐ No

PAST MEDICAL HISTORY (Have you been diagnosed with any of the following? Please check all that apply.)

- ☐ Allergies
- ☐ Anesthesia Complications
- ☐ Aneurysm
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Autoimmune Disorder;Type:_____
- ☐ Cancer; Type: _____
- ☐ Head and Neck Cancer
- ☐ Glaucoma/Cataracts
- ☐ Cerebral Palsy
- ☐ Cochlear Implant
- ☐ COPD/Emphysema
- ☐ COVID-19
- ☐ Hearing Loss
- ☐ Diabetes
- ☐ Difficulty swallowing
- ☐ GERD/Reflux
- ☐ Keloids/Poor Scaring
- ☐ Kidney Disease
- ☐ Lung Disease
- ☐ Head Injury
- ☐ Heart Disease
- ☐ Hepatitis; Type:_____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Mental Disorder
- ☐ Migraines
- ☐ Nasal Polyps
- ☐ Pacemaker
- ☐ Radiation Treatments
- ☐ Sleep Apnea
- ☐ Speech Delay
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tinnitus
- ☐ Tuberculosis
- ☐ Vitamin D Deficiency
- ☐ Wound Healing Complications
- ☐ Other:_____

PAST SURGICAL HISTORY

Name of Surgery	Date	Surgeon/Facility

FAMILY HISTORY (Do any family members have any of the medical problems listed below?)

	Relationship		Relationship
☐ Anesthetic Complications		☐ Heart Disease	
☐ Asthma		☐ High Blood Pressure	
☐ Autoimmune Disorders		☐ High Cholesterol	
☐ Bleeding Disorders		☐ Kidney Disease	
☐ Cancer; Type:		☐ Liver Disease	
☐ Diabetes		☐ Sleep Apnea	
☐ Hearing Loss		☐ Stroke	
		☐ Thyroid Disease	

SOCIAL HISTORY (State all current and previous substance use)

Do you use Tobacco? (cigarettes,vape,cigars,pipe,snuff/chew) ☐ **Yes** ☐ **No**

If **Yes** please indicate **TYPE** and **Frequency**:_____ _____per day for _____years

If you quit using tobacco please list the year you quit:_____ How many years did you use tobacco?_____

Do you use alcohol? ☐ **Yes** ☐ **No** If yes, how many a week?_____

If you quit using alcohol please list the year you quit: _____ How many years did you drink?_____

Do you use recreational or addictive drugs? ☐ Yes ☐ No If yes, which?_____

Occupation (if retired, state former):_____

Do you have any children? ☐ Yes ☐ No If yes, how many?_____

PEDIATRIC - UNDER 18

Birth weight:___lbs___oz **Was the baby born at term?** ☐ Yes ☐ No Weeks:_____ Current Weight:_____

Were there any prenatal or neonatal complications? ■ Yes ☐ No

If yes, explain:_____

Was a NICU stay required? ☐ Yes ☐ No **Newborn hearing screen results:** ☐ Pass ☐ Fail ☐ Unknown

Does the patient attend school, preschool or daycare? ☐ Yes ☐ No **Current grade in school:** _____

Do any household members smoke? ☐ Yes ☐ No If yes, who?_____

Who does the patient live with?_____ **Number of siblings?**_____

Is there OCS involvement? ☐ Yes ☐ No If yes, explain_____

X_____ _____

PATIENT or RESPONSIBLE PARTY SIGNATURE **TODAY'S DATE**