

**EDWARD H FARRIOR, MD, FACS
CONSULTATION MEDICAL HISTORY**

Name: _____ Age: _____ Height: _____ Weight: _____ Date of Last Physical: _____

Name, Address and Phone # of Primary Physician: _____

What is your daily consumption of: Tobacco: _____ Alcohol: _____
If you have smoked in the past; how much, how long, and when did you stop? _____

Please list all previous surgery, including cosmetic, serious illnesses, or hospitalizations, including childbirth:

Operation or Hospitalization: _____ Year: _____ Anesthesia (local/general): _____

List all current medications, including dosages. Please include all over the counter medicines such as aspirin, vitamins, etc.

Please indicate if you have ever had or suffered from the following medical conditions:

- | | | | |
|---------------------------------------|--|---------------------------|--|
| Could you possibly be pregnant | <input type="checkbox"/> No <input type="checkbox"/> Yes | Blood transfusion | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Radiation therapy for acne as a child | <input type="checkbox"/> No <input type="checkbox"/> Yes | Sleep Apnea | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Tuberculosis | <input type="checkbox"/> No <input type="checkbox"/> Yes | Kidney Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Cancer | <input type="checkbox"/> No <input type="checkbox"/> Yes | HIV | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Diabetes | <input type="checkbox"/> No <input type="checkbox"/> Yes | Depression/Mental Illness | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Heart Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | Gastrointestinal Problems | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Lung Disease / Asthma | <input type="checkbox"/> No <input type="checkbox"/> Yes | Hepatitis / Liver Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Nasal Trauma | <input type="checkbox"/> No <input type="checkbox"/> Yes | Nasal Obstruction | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Previous Nasal Surgery | <input type="checkbox"/> No <input type="checkbox"/> Yes | High Blood Pressure | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Blurred Vision | <input type="checkbox"/> No <input type="checkbox"/> Yes | Double Vision | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Dry Eyes | <input type="checkbox"/> No <input type="checkbox"/> Yes | | |

Are you on any dietary supplements or suppressants? No Yes

If yes, please list: _____

Have you or a family member ever had a reaction to general anesthesia? No Yes

Have you or a family member ever been diagnosed with a bleeding disorder? No Yes

Drug Allergies and Sensitivities: _____

I acknowledge that I have disclosed all of my medical history known to me:

Patient's Signature: _____
(date)

MD: _____
Edward H Farrior, MD, FACS

For office use only: -----
No changes to medical history: _____
(initials) (date)

No changes to medical history: _____
(initials) (date)