

Medical History - Rhinoplasty

Name: _____ Age _____ Male Female Today's Date _____

Date of Birth _____ Primary Care Doctor Name & Address: _____

Primary Care Doctor Phone: _____

----- Present Illness -----

Reason for consultation? _____

List previous nasal surgeries _____

List previous nasal injuries _____

Describe any breathing difficulties _____

Duration of the problem? _____ Have you had any treatment for this? _____

Your goals for this problem or what do you hope to achieve? _____

Date of injury (if any): _____ Do you have legal action pending regarding this problem? No Yes

Attorney name & phone: _____

----- Past Medical History -----

List previous surgeries:

Year	Surgery	Right/Left?	Year	Surgery	Right/Left?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

List Hospitalizations other than surgeries:

Year	Reason	Year	Reason
_____	_____	_____	_____
_____	_____	_____	_____

Visits to the Emergency Department or Urgent Care in the last year:

Year	Reason	Year	Reason
_____	_____	_____	_____

Other medical conditions not mentioned above:

List all current medications including contraceptives:

Drug	Dose	Reason for taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Herbs/Supplements	Reason for taking
_____	_____
_____	_____

<u>Allergies</u>	No	Yes
Local anesthetic	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa	<input type="checkbox"/>	<input type="checkbox"/>

	No	Yes
Iodine	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Tape	<input type="checkbox"/>	<input type="checkbox"/>

Other Drug Allergy Reaction

Other Drug Allergy Reaction

----- **Family History** -----

Age (if alive)	Health status	Age (at death if deceased)	Cause of Death
Mother _____			
Father _____			

Have your mother/father/sisters/brothers had any of the following? Explain any "yes" answers below.

	No	Yes
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (list type)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>

	No	Yes
Problems with anesthesia	<input type="checkbox"/>	<input type="checkbox"/>
Describe _____		
Sickle Cell	<input type="checkbox"/>	<input type="checkbox"/>
Skin Cancer (list type)	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>

----- **Social History** -----

Single Married Widowed Divorced

Currently employed? No Yes Occupation _____

Smoking: Never smoked Currently smoking Quit smoking When? _____

In the past, I have smoked a total of _____ years averaging _____ packs per day.

Do you drink alcohol? No Yes How many drinks per week? _____

Current drug abuse? No Yes Type of drug: _____

I live with _____ adults and _____ children.

----- **Review of Systems** -----

Have you ever had any of the following? Explain any "yes" answers below.

General No Yes
 Organ transplant

Stomach ulcers
 Eating Disorder
 Black stools

Cancer No Yes
 Cancer (type?) _____

Genetic/Inherited Disease No Yes

 Type: _____

Endocrine No Yes
 Diabetes
 Thyroid
 Adrenal
 Nipple discharge
 Breast lumps
 Breast infections

Genitourinary No Yes
 Blood in urine

Gastrointestinal No Yes

Heart/Blood/Circulatory No Yes
 High Blood Pressure
 Chest Pain
 Palpitations/ abnormal rhythm
 Heart Attack

Heart Failure
 Sickle Cell Anemia
 Heart Valve
 Heart Murmur
 Bleeding Tendencies
 Easy bruising
 Frequent Nose bleeds
 Pacemaker

Immune System No Yes

Lupus
 Sjogren's Syndrome
 HIV/AIDS

Kidney No Yes

Kidney failure
 Dialysis
 Nephrotic Syndrome

Liver No Yes

Hepatitis (type & status)
 Cirrhosis
 Liver Failure

Lungs No Yes

Emphysema
 Oxygen use at home
 Shortness of breath while lying down

Shortness of breath after one flight of stairs
 Sleep Apnea
 Asthma
 Tuberculosis
 Pneumonia
 Bronchitis
 Recent Coughing

Musculoskeletal No Yes

Prosthetic join (where) _____

Neurological No Yes

Epilepsy/Seizures
 Stroke/TIA
 Blackout/Fainting
 Depression
 Phobias
 Anxiety/Panic attacks
 Suicide attempt in past
 Other Mental Illness (type?)

Presurgical No Yes

Problems with Anesthesia
 Could you be pregnant?
 Vericose Veins
 Family History of Blood Clots
 Personal History of Blood Clots

Skin No Yes

Acutane use

Explain any "yes" answers.

Height _____ Weight _____

Signature of: patient /mother /father /legal guardian _____