

ORL, Inc.

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PLEASE FILL OUT THIS FORM AND BRING WITH YOU TO YOUR APPOINTMENT!

Thank you for selecting our practice. In order to better serve you, please bring this completed form.
Appointment Date _____

Patient Name _____ Birth Date _____ Age _____

I. Past Medical History

****Please circle any of the following medical conditions that affect you:****

None - I am in excellent health

Diabetes (high sugar)	Thyroid disease	Stomach ulcers	Cancer
Stroke	Kidney disease	AIDS or HIV+	Tuberculosis
High blood pressure	Liver disease	Seizure disorder	
Arthritis	Lung disease	Hepatitis B or C	

Any other medical problems?

****Please circle any prior Ear, Nose, or Throat surgeries:****

None	Ear tubes	Tonsils	Adenoids	Sinus Surgery	Nasal Surgery
Major Ear surgery	Skin Cancer Excisions	Neck Surgery	Facial Plastic Surgery		

Other Ear, Nose, or Throat Surgeries?

Any other types of surgeries?

****Please list your medications:****

****Please list any allergies to medications and what happens if you take it:****

_____ No known allergies to medicine

<u>Medication</u>	<u>Reaction</u>	<u>Medication</u>	<u>Reaction</u>
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II. Social History (Please Circle Appropriate Responses)

Use of Alcohol:	Never	Rarely or Moderately	Daily	Previous Alcohol Problems
Use of Tobacco:	Never	Previously, but quit _____		Current Packs per day How many years

III. Family History

Any family members with Ear, Nose, or Throat cancer and what type?
 Any family members with permanent hearing loss when they were younger than 30 years old?
 Any family members with bleeding disorders?

-Over-

IV. Review of Systems

Please put a check in front of those that apply to you:

Constitutional:

___ Weight loss more than 20 pounds in 6 months ___ Nightly fevers ___ Nightly chills or shaking

Eyes:

Double vision Eye disease or injury Change in vision with headache

Cardiovascular:

Palpitations Heart murmurs Chest pain/heart attack

Respiratory:

Chronic dry cough Coughing blood Snoring Hoarseness
 Shortness of Breath

Gastrointestinal:

Nausea or vomiting during dizziness Nausea or vomiting during headache Heartburn

Genitourinary:

Blood in urine Kidney stones Frequent Urination

Musculoskeletal:

Joint pain Neck or shoulder pain Joint stiffness or swelling

Skin:

Eczema or rash Skin cancers

Neurological:

Numbness or tingling in face Headaches Head injury

Endocrine:

Weight Gain Weight Loss Constipation Frequent Bowel Movements
 Dry Skin Excessive Sweating Chronic Fatigue Inability to Sleep

Hematologic:

Bleed or bruise easily Past blood transfusion Anemia

Authorization and release

To the best of my knowledge, the questions on this form have been correctly answered. I understand that providing incorrect information can have an adverse impact on my health. It is my responsibility to inform the physician's office of any changes to my medical status. I also authorize the health care staff to perform the necessary services I may need.

Signature of patient--If minor, signature of parent or legal guardian

Date

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