Alyeska Center for Facial Plastic Surgery/ENT
3831 Piper St Ste S-433
Anchorage, AK 99508

_____ _____
Name Date of Visit

How did you hear about us: _____
Reason for Visit: _____

Medical History
Do you now or have you ever had a history of:

1. Abnormal bleeding or a bleeding disorder	Yes	No
2. Anesthetic complications	Yes	No
3. Diabetes	Yes	No
4. Heart disease (heart attack, chest pains, irregular heartbeat, congestive failure)	Yes	No
5. Lung disease	Yes	No
6. Wound healing complications	Yes	No
7. Keloids or poor scarring	Yes	No
8. Heart murmur requiring preventative antibiotics	Yes	No
9. Radiation treatments	Yes	No
10. Tuberculosis	Yes	No
11. Hepatitis or liver disease	Yes	No
12. Gastric or peptic ulcers	Yes	No
13. Stroke	Yes	No
14. Cancer	Yes	No
15. Kidney disease	Yes	No
16. Psychiatric illness	Yes	No
17. Implants or artificial devices (i.e. heart valve, joints, lens, pacemaker)	Yes	No
18. Eye disease (glaucoma, retinal detachment, cataracts)	Yes	No
19. High blood pressure	Yes	No
20. Inflammatory, or autoimmune disease (lupus, wegener's, sarcoid, MS)	Yes	No
21. HIV or AIDS	Yes	No
22. Family history of abnormal bleeding or anesthetic complications	Yes	No
23. Other medical problems	Yes	No
24. Do you have any religious reason why you would not accept blood products	Yes	No
25. Have you or anyone in your family been treated for a MRSA skin infection	Yes	No

If you answered yes to any of the above, please provide details below: _____
_____
_____

List all prescriptive and over the counter medications:

List all ALLERGIES to MEDICATIONS:

******PLEASE COMPLETE OTHER SIDE******

(w: patienthistoryinfo)

NAME: _____ DATE OF BIRTH: _____

List all prior SURGERIES and HOSPITALIZATIONS:

Family and Social History:

Occupation: _____

Tobacco use (cigarettes, cigars, pipes, chew, snuff):	Years of use	Packs per day	Year quit
	_____	_____	_____

Do you consume alcoholic beverages regularly?	Yes	No
Do you use illicit or addictive drugs (cocaine, marijuana, etc.)	Yes	No
If female, is there a chance you might be pregnant	Yes	No

Please list any illnesses that run in your family:

Check any of the following that you are currently or have previously experienced:

General			Eyes		
Rashes/bruising/skin problems	Now	Past	Clouded vision	Now	Past
Recent weight loss or gain	Now	Past	Dry eyes	Now	Past
Fatigue	Now	Past	Double vision	Now	Past
Fever/chills/night sweats	Now	Past			
			Ears		
Sleep Disturbance			Ringing	Now	Past
Loud snoring	Now	Past	Hearing loss	Now	Past
Excessive sleepiness	Now	Past	Dizziness/vertigo	Now	Past
Breathing stops during sleep	Now	Past	Pain	Now	Past
Wake up feeling unrested	Now	Past	Drainage	Now	Past
Cardiopulmonary			Mouth/Throat		
Heart murmur	Now	Past	Dryness	Now	Past
Palpitations	Now	Past	Hoarseness	Now	Past
Chest pain	Now	Past	Choking	Now	Past
Shortness of breath	Now	Past	Difficulty swallowing	Now	Past
Wheezing	Now	Past	Lumps in neck	Now	Past
Chest tightness	Now	Past	Painful swallowing	Now	Past
Nervous System			Nose		
Numbness	Now	Past	Nasal congestion	Now	Past
Tingling	Now	Past	Nasal drainage	Now	Past
Fainting	Now	Past	Facial pressure/pain	Now	Past
Weakness	Now	Past	Nasal bleeding	Now	Past
Endocrine			Gastrointestinal		
Heat/Cold intolerance	Now	Past	Indigestion/heartburn	Now	Past
Excessive thirst	Now	Past	Nausea/vomiting	Now	Past
Change in shoe/hand size	Now	Past	Change in stool color	Now	Past
			Diarrhea/constipation	Now	Past
			Abdominal pain	Now	Past

(w: patienthistoryinfo)