DECATUR ENT ASSOCIATES
1218 13TH Avenue, S.E., Decatur · AL 35601
Phone (256) 355-6200

INITIAL HISTORY FORM

LIGHT FACIAL PLASTIC SURGERY
1218 13TH Avenue, S.E. · Decatur, AL 35601
Phone (256) 351-2000 · 1 (866) 239-FACE

Name ______________________________ Age __________ D.O.B.__________________

Reason for Visit ______________________________ Duration ______________ Today's Date__________

PLEASE CHECK THE PROBLEMS THAT APPLY TO YOU (No checks mean no problems)

REVIEW OF SYSTEMS

Constitutional:	□fever	□chill		
Eyes:	□excessive tearing	□itchy eyes		
Cardiovascular:	□irregular heart	□syncope(fainting)	□lightheadedness	□high blood pressure
Respiratory:	□shortness of breath	□wheezing	□cough	□coughing up blood
Gastrointestinal:	□heart burn	□irritable bowel		
Genitourinary:	□Urinary hesitancy	□prostate trouble		
Integument:	□skin rash	□itching skin		
Neurologic:	□incoordination	□tingling / numbness	□loss of balance	□loss of consciousness
Musculoskeletal:	□joint pain	□limitation of motion	□muscular weakness	
Psychiatric:	□anxiety	□depression		
Heme-Lymph:	□easy bleeding	□easy bruising		
Allergic-Immunology:	□allergic dermatitis	□frequent illness		

PERSONAL HISTORY:

Tobacco Use: ____Yes _____No
How Often_________ Amount Used _________
Age Started________ Age Stopped _________

Alcohol Use: _____Yes ____No
How Often ________ Amount Consumed ________
Age Started_______ Age Stopped __________

PATIENT HISTORY:

____Glaucoma	____High Blood Pressure
____Seizures	____Heart Attack
____Arthritis	____Heart Failure
____Asthma	____Stroke
____Ulcers	____Mitral Valve Prolapse
____Hepatitis	____Rheumatic Fever
____Diabetes	____Kidney/Bladder
____Thyroid	____Migraine

____Other____
____

Check box if any of these apply to patient
- □ Exposure to second hand smoke?
- □ Exposure to tobacco smoke in the perinatal period?
- □ History of tobacco use?
- □ Exposure to smoke at work?
- □ Tobacco dependence?
- □ Tobacco use?

PREVIOUS SURGERY: (List ALL Surgery)______________
____
____
____

MEDICATIONS NOW TAKING: (including Aspirin or over-the-counter medicines)
Type & Date:______________________________________
____
____
____

OCCUPATION:_______________________________________

PHARMACY OF CHOICE:_______________________________

DRUG ALLERGIES:___________________________________
____

FAMILY PHYSICIAN:_________________________________
REFERRING PHYSICIAN:______________________________

FAMILY HISTORY:

_____Hearing Loss
_____Allergy
_____Heart Disease/Blood Pressure
_____Cancer
_____Anesthesia Problem
_____Bleeding Disorders
_____Muscular Dystrophy
_____Other________________________________

Mother Alive_______ Deceased_______
Cause________________________________
Father Alive_______ Deceased_______
Cause________________________________

Are you receiving any Hospice or Home Heath Care?
_____Yes ______No
Updated______________ Updated____________
Updated______________ Updated____________