FAIRFAX ENT & FACIAL PLASTIC SURGERY

Dr. Laurence R. O'Halloran MD, Dr. Timothy J. Egan MD, & Dr. Heinz H.E. Scheidemandel MD Otolaryngology-Head and Neck Surgery • Facial Plastic Surgery

Welcome to our office. Please complete these forms as completely and accurately as possible.

TODAY'S DA	TE:						
PATIEN	ΓINFO	DRMAT	ION				
Patient's Last Nam	е			Firs	t Name		Middle Initial
Parent Name (if Pa	atient is a mir	nor)					
Patient Age	Date	e of Birth	Sex:			Social	Security Number
ratient Age	Date	: Of Bildi	Jex.	Male	Female	Social	Security Number
Marital Status	Single	Married	Divorced	Sep	parated	Widowed	
Home Address				City		State	Zip
Home Phone			Work Phone			Cellular Pho	ne
E-Mail Address							
Your Occupation			Your En	nployer			
Spouse Name			Spouse's	s Employe	r		
Whom May We Th	ank for Refer	ring You to Our	· Practice?				
NOTIFY	IN CA	SE OF	EMERGE	NCY	7		
Name					ļ	Relationship	
Home Phone			Work Phone			Cellular Pho	ne
Nearest Relative (not living wit	h you)					
Home Phone			Work Phone			Cellular Pho	ne
WHO IS	YOUR	DOCT	OR? (PRI	MAR	CARE A	AND SPECIAL	IST)
Physician Name		Specialty	Address				
Signature : Signature :			 				
Signature :							
Signature :	·				Date: _		

Primary Insurance Name		Telephone Number			
Claim Address		City	State	Zip	
Policy Holder's Name	Relation To Patient	Policy Holder's Date of Birth	Subscriber	r's SS Number	
Insurance ID		Group #			
SECONDARY I	NSURANCE				
Secondary Insurance Name		Telephone Number	er		
Claim Address		City	State	Zip	
Policy Holder's Name	Relation To Patient	Policy Holder's Date of Birth	Subscribe	er's SS Numbe	
Insurance ID		Group #			
MY PHARMAC	Y				
Pharmacy Name	Location	!	Phone Number		
PATIENT RES	PONSIBILITY				
PATIENT RESP		reement and sign below.			
Please read our Financial		reement and sign below.			
Please read our Financial Medical Records	Policy Statement and Ag	reement and sign below. e submissions. I authorize the	e release of	my	
Please read our Financial Medical Records I authorize the use of this medical information to all	Policy Statement and Ages form on all my insurance my insurance companies	e submissions. I authorize the	e release of	my	
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MEDICAL HISTORY
What is the reason for your visit?
How long have you had the problem?
How severe is the problem?
Prior treatments

Name:

			EMS DO YOU HAVE?
NO	YES	PROBLEM	DATE / DETAILS
		Major Illness	
		Major Injury	
		Hospitalization	
		Acid Reflux	
		Anemia	
		Asthma	
		Bleeding / Bruising Problems	
		Blood Clots	
		Cancer	
		Diabetes	
		Heart Problems	
		High Blood Pressure	
		Kidney Problems	
		Liver Problems	
		Lung Problems	
		Thyroid Problems	
		CHILDREN ONLY	
		Born Premature	
		Congenital Defects	
		Reading/Learning Disability	
		WOMEN ONLY	
		Are you pregnant?	

WHAT SURGERIES H	AVE YOU HAD	?
NO YES PROCEDURE NAME	DATE	SURGEON / LOCATION
Tonsillectomy	DATE	SURGEON / LUCATION
Adenoidectomy		
Ear Surgery		
Nose Surgery		
Throat/Neck Surgery		
Anesthesia Problems		
OTHER Please list		
CITIZA / Jodge metin		
		-
PLEASE LIST ALL OF	VOLID MEDIC	ATTONS
PLEASE LIST ALL OF	TOUR MEDICA	ATIONS
■ NONE (include over the	e counter medicat	tions)
`	NAME / DOSE	,
Antacids/ Heartburn Meds	NAME / DOSE	
Antibiotics		
Aspirin Birth control pills		
Blood pressure pills		
Beta Blockers		
Blood thinner		
Diabetes pills		
Pain pills		
Tranquilizers		
Vitamin E		
Water pills		
Tracer pino		
1		
ARE YOU ALLERGIC 1	CO ANY MEDIA	CATTONES
ARL TOO ALLERGIC	O AINT MEDIC	
□ Yes		NO
NAME OF DRUG	KEACTION (e.g. Hi	ives, Wheezing, Anaphylaxis)

Name:

Name:

SC	CI	AL HISTORY / HABITS	S / RISK FACTORS
NO	YES	QUESTION	DETAILS
		Tobacco:	
		Cigarettes	No packs/day:
		Cigars / Pipe / Chewing Tobacco	Quantity:
		Have you ever smoked in the past?	Date started: Date stopped:
		Alcohol:	Never Rarely Socially Daily Alcoholic
		Beer / Wine / Liquor	
		Drugs:	
		Cocaine / Marijuana /	
		Family:	
Child	Children		Number: Ages:
Occi	Occupation		

FA	MI	LY HISTORY			
NO	YES	PROBLEM	RELATION	YEAR	FOR DOCTOR NOTES
		Allergies			
		Asthma			
		Arthritis			
		Bleeding problems			
		Cancer			
		Diabetes			
		Heart Trouble			
		Mental Illness			
		Migraine headaches			
		Stroke			
		Thyroid Disease / Goiter			
		Tuberculosis			
		Ear Infections			
		Otosclerosis			
		Glaucoma			
		Hearing Loss			
		Other: please list:			

D(DO YOU HAVE TROUBLE HEARING?				
No	Yes				
		Do you have trouble hearing in noisy environments?			
		Does anyone ever complain about your hearing?			
		Do you use or own hearing aids?			
		Have you ever been told that you would benefit from hearing aids?			

Name:

DO	YO	U HAVE ANY OF THE	FO	Ц	OWING SYMPTOMS?
NO	YES		NO	YES	
		CONSTITUTIONAL			GASTROINTESTINAL
		Weight Loss or Gain			Nausea/Vomiting
		Fatigue			Heartburn
		Fever/ Chills			Bowel Changes
		VOICE AND THROAT			Abdominal Pain
		Change in Voice			CARDIOVASCULAR
		Trouble Swallowing			Chest Pain
		Sore Throat			Leg Swelling
		EARS			URINARY / REPRODUCTIVE
		Hearing Loss			Do you think you could be pregnant now?
		Ringing or ear noise			Difficulty urinating
		Pain in ears			MUSCULOSKELETAL
		Dizziness/Imbalance			Pain in Neck
		MOUTH AND NECK			Stiff Joints
		Lumps in neck			PSYCHIATRIC / EMOTIONAL
		Headaches			Anxiety
		Nosebleeds			Depression
		EYES			NEUROLOGIC
		Blurred Vision			Numbness
		Double Vision			Weakness/Paralysis
		RESPIRATORY			Tingling
		Cough			Difficulty Walking
		Wheezing			Skin
		Shortness of Breath			Itching/ Rash
		Coughing up Blood			Non healing lesion
		ENDOCRINE / METABOLIC			Hematological
		Heat or Cold Intolerance			Bleeding or Bruising
		Hair Change			Enlarged Lymph Nodes

Reviewed by Patient: Signature:	Date:
Signature:	Date:
PHYSICIAN : I have reviewed the PMH,	SH, FH and ROS