DeFatta ENT
FACIAL PLASTIC SURGERY

Vitals (Medical Assistant will Complete)	
Ht	Temp
Wt	B/P
Resp	Pulse

Patient Name: _____
Birthdate: _____
Email: _____
Primary Doctor: _____

Medications You are Taking Now and Dose (if known)			
Name of Drug/Dose	Date Started	Name of Drug/Dose	Date Started
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	
Drug Allergies & Reactions:			
Medical & Surgical History:			
Family History:			
Are you a smoker or tobacco user? Yes No Do you have a history of smoking? Yes No Any exposer to 2nd hand smoke? Yes No		Drink Caffeine? Yes No If yes, # servings/day_____ Drink Alcohol? Yes No If yes, # servings/wk _____	
Marital Status: Married Single Widowed Divorced		Work: Fulltime Part time Retired Unemployed	

Do you **currently** have or **previously** had any problems related to the following systems?

Constitutional Symptoms			**Integumentary**		
Fever	Yes ☐	No ☐	Skin Rash	Yes ☐	No ☐
Chills	Yes ☐	No ☐	Persistent Itch	Yes ☐	No ☐
Eyes			Moles/Discolored Spots	Yes ☐	No ☐
Blurred/ Double Vision	Yes ☐	No ☐	**Musculoskeletal**		
Itchy/Watery Eyes	Yes ☐	No ☐	Joint Pain	Yes ☐	No ☐
Pain	Yes ☐	No ☐	Neck Pain	Yes ☐	No ☐
Neurological			Back Pain	Yes ☐	No ☐
Tremors	Yes ☐	No ☐	**Ear/Nose/Throat**		
Dizzy Spells	Yes ☐	No ☐	Ear Pain/Hearing Loss	Yes ☐	No ☐
Numbness/Tingling	Yes ☐	No ☐	Sore Throat	Yes ☐	No ☐
Migraines	Yes ☐	No ☐	Swallowing Problems	Yes ☐	No ☐
Headaches	Yes ☐	No ☐	Sinus Problems	Yes ☐	No ☐
Endocrine			**Respiratory**		
Excessive Thirst	Yes ☐	No ☐	Wheezing	Yes ☐	No ☐
Too Hot/Too Cold	Yes ☐	No ☐	Frequent Cough	Yes ☐	No ☐
Tired/Sluggish	Yes ☐	No ☐	Shortness of Breath	Yes ☐	No ☐
Gastrointestinal			**Hematologic/Lymphatic**		
Abdominal Pain	Yes ☐	No ☐	Swollen Glands	Yes ☐	No ☐
Indigestion/Heartburn	Yes ☐	No ☐	Bleeding/Clotting Problem	Yes ☐	No ☐
Diarrhea/constipation	Yes ☐	No ☐	**Psychiatric**		
Cardio			Insomnia	Yes ☐	No ☐
Heart Attack	Yes ☐	No ☐	Depression	Yes ☐	No ☐
Atrial Fibrillation	Yes ☐	No ☐	Anxiety	Yes ☐	No ☐

Dr. Signature_____ _____Date_____