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.		5.	
2.		6.	
3.		7.	
4.		8.	
Drug Allergies & Reactions:			
Medical History:			
Surgical History:			
Family History:			
Caffeine use? Yes No Any exposure to 2nd hand smoke? Yes No Exercise regularly? Yes No		Currently in School? Yes No Currently in Daycare? Yes No Lives with Parents? Yes No Lives with Foster Parents? Yes No N/A	

Circle all that currently apply:

Fatigue	Fever	Chills	Recent Weight Loss	Nausea
Vomiting	Sneezing	Frequently Sick	Eye Pain	Double Vision
Blurry Vision	Watery Eyes	Itchy Eyes	Ear pain	**Hearing Loss**
Ear Drainage	Nosebleeds	Nasal Discharge	Nasal Passage Blockage	Snoring
Sinus Pain	Sore Throat	Neck Mass	Hoarseness	**Speech Delay**
Difficulty Breathing	Heart Murmur	Wheezing	Noisy Breathing	Cough
Trouble/Pain Swallowing	Abdominal Pain	Diarrhea	Constipation	Bleeding Problems
Clotting Problems	Lymph Node Enlargement	Neck Pain	Joint Pain	Back Pain
Persistent Itch	Moles/Discolored Spots	Skin Rash	Headache	Difficulty with Balance
Fainting	Seizure	**Delayed Milestones**	Anxiety	Depression
Daytime Sleepiness	Insomnia			

Doctor Signature_____ _____Date_____

Doctor Signature________________ _______________________________Date___________________________