Omar A. Fadhli, M.D.
FELLOW AMERICAN ACADEMY OF OTOLARYNGOLOGY

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FLORIDA
ENT ADULT & PEDIATRIC, PA

OTOLARYNGOLOGY – HEAD & NECK SURGERY – EAR & SINUS SURGERY – FACIAL PLASTIC & SKIN CANCER SURGERY – THYROID SURGERY

HISTORY

(Please fill out as completely as possible using black ink)

NAME_____BIRTHDATE_____ AGE_____ PRIMARY CARE DOCTOR_____

PHARMACY (NAME)_____(LOCATION)_____ HEIGHT _____ WEIGHT _____

PROBLEM YOU ARE SEEING THE DOCTOR FOR:_____
_____

PREVIOUS & CURRENT MEDICAL CONDITIONS *CIRCLE all that apply to you: IF NONE: circle: NO PROBLEM: Bleeding Disorder, HIV, Hepatitis, Hypertension, Heart Disease, Cholesterol, Diabetes, Stroke, TIA, Asthma, COPD, Pneumonia, Cancer, Thyroid, Liver, Renal Insufficiency, Prostate, Migraines, Depression, Anxiety, Fibromyalgia, Arthritis, Cataract, Decreased Vision, Glaucoma, Vertigo, COME, COE, CHL, SNHL, Facial Paralysis, Inferior Turbinate Hypertrophy, Deviated Septum, Chronic Sinusitis, Polyps, Allergic Rhinitis, Ch. Tonsillitis, Snoring, Sleep Apnea, GERD, TVC Paralysis, TVC nodules,* ***Currently Pregnant*** *)*

1._____ 4._____ 7:_____

2._____ 5._____ 8._____

3._____ 6._____ 9._____

PREVIOUS SURGERIES: *CIRCLE all that apply IF NONE circle: NO SURGERIES.*
Ear Tubes, Tympanoplasty, Mastoidectomy, Septoplasty, ITR, Sinus Surgery, Rhinoplasty, T&A, UPPP, BOT reduction, Thyroidectomy, Heart Bypass, Pacemaker, Stents, Angioplasty, Cholecystectomy, Hernia, Esophagoscopy, Colonoscopy, Hysterectomy, C-section, Prostate, Back, Neck, Hip, Knee, Cataract

1._____ 3._____ 5._____

2._____ 4._____ 6._____

MEDICATIONS CURRENTLY TAKING WITH DOSE *(INCLUDE VITAMINS AND NON-PRESCRIPTIONS LIKE ASPIRIN)*:

1._____ 4._____ 7._____

2._____ 5._____ 8._____

3._____ 6._____ 9._____

ALLERGIES TO MEDICATION: NONE / YES TO:_____

SMOKING YES / NO HOW MUCH PER DAY_____ HOW MANY YEARS_____
EXPOSER SECOND HAND SMOKE YES / NO
ALCOHOL YES / NO HOW MUCH PER DAY_____ HOW MANY YEARS_____
CAFFEINE YES / NO HOW MUCH PER DAY_____
PETS YES / NO CATS, DOGS, BIRDS, OTHER_____
MARITAL STATUS: S, M, D, W AGES OF CHILDREN:_____
PLACE OF CURRENT OR LAST EMPLOYMENT:_____DUTIES:_____

FAMILY HISTORY OF DISEASES (*CIRCLE)*: *None of the Following, Bleeding Disorder, Hearing Loss, Cardiac, Cancer, Stroke, Diabetes, Arthritis, Depression, Drug Use, Hepatitis HIV*_____

Please Do Not Write Below This Line

ROS:	Constitutional	(____WNL)	Gastrointestinal	(____WNL)	Psychiatric	(____WNL)
	Eyes	(____WNL)	Genitourinary	(____WNL)	Endocrine	(____WNL)
	Cardiovascular	(____WNL)	Musculoskeletal	(____WNL)	Hematologic/Lymphatic	(____WNL)
	Respiratory	(____WNL)	Integumentary	(____WNL)	Allergic/Immunologic	(____WNL)
	Ears, Nose, Throat & Mouth – As Above		Neurological	(____WNL)		

REVIEWED & UPDATED BY OMAR A. FADHLI M.D. DATE