Tufts Medical Center Department of Otolaryngology-Head and Neck Surgery
Data Collection form – Dr. Richard Wein/Dr. Miriam O'Leary

Name: _____ Age:_____ Primary Care Physician: _____

Why are you here today?:

Past Medical History: Check (√) any current or past **medical problems**:

_ Nasal Allergies/Hay fever	_ Heart Attack	_High Blood Pressure
_Stroke	_Seizures	_Mental Health Problems
_Kidney Problems	_Hepatitis/Liver Disease	_Bleeding Disorders
_Blood Disorder	_Thyroid Disease	_Tumor/Cancer
_Asthma/Lung Disease	_Diabetes	_Sexually Transmitted Disease

_Other(s) (Please Specify): _____

Past Surgical History: Please list past **surgeries** and include date of procedure

_____
_____
_____

Medications/Allergies: Please see other sheet

Are you currently taking any of the following **medications**? (If yes, **please circle**)

Aspirin	Vitamin E	St. John's Wort	Echinacea	Garlic
Ginkgo	Ginseng	Ephedra	Kava	

Family History- Circle any of the following diseases that run in your family:

Diabetes	Mother	Father	Sister	Brother
Heart Disease	Mother	Father	Sister	Brother
High Blood Pressure	Mother	Father	Sister	Brother
Cancer	Mother	Father	Sister	Brother

Social History

Do you use tobacco products now or have you in the past? YES NO
If yes, please specify: Cigarettes/Cigars/Pipe/Chewing Tobacco
If cigarettes, packs per day_____ Number of Years_____
Are you still using tobacco products? YES NO
Do you drink alcohol regularly? YES NO
If yes, how many drinks per day?_____
What is your current or former occupation?_____

Would you like to quit smoking?

___Yes ___No

Review of Systems: Check all symptoms that you are **currently** or have **recently** experienced:

__Unexplained weight loss	__Fevers/Night sweats
__Change in Vision	__Heat/Cold Intolerance
__Dizziness	__Shortness of breath
__Chest Pain	__Bleeding/bruising easily
__Diarrhea	__Constipation
__Muscle or joint pain	__Numbness in extremities

__Other:_____

Patient's Signature:_____ Date:_____

Confirmed by:
Physician's Signature:_____Date: _____