



Advanced Technology ★ Personalized Care
 Sewell, NJ 856-589-NOSE and 1-888-SINUSES (NJ, NY, and PA)

Services About Us Technology Educational

FAQs In the News Contact Us Home

Board Certified Sinus Surgeon, American Board of Otolaryngology

"Trust your nose and sinuses to a specialist."

PATIENT INFORMATION SHEET

Name: _____

Address: _____

E-mail address: _____

DOB: _____

Phone numbers:
Home _____
Work _____
Fax _____

Please list the names of your referring physician if applicable, and other physicians whom you would like to receive a report:

 physician name

 physician name

 street address

 street address

 city, state, zip code

 city, state, zip code

 phone number

 phone number

 physician name

 physician name

 street address

 street address

 city, state, zip code

 city, state, zip code

 phone number

 phone number

Please state the reason for this consultation.

Have you ever had surgery before, including plastic surgery? If so, please list, including (approximate) year-of-surgery.

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.

Have you ever had traumatic injury to your nose (i.e., a broken nose)?

Please list any medical problems for which you have received or are receiving care for.

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.

Do you take any medications? Please list below

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.

Have you ever been hospitalized? _____ Yes _____ No

If yes, please list:

Do you take aspirin, or any products with aspirin in it? _____ Yes _____ No

If so, how much & how often?

Do you have any drug allergies? _____ Yes _____ No
 If yes, please list all, and list what your reaction was:

Do you have environmental allergies? _____ Yes _____ No
 If yes, have you had allergy shots? _____ Yes _____ No
 If yes, did they help? _____ Yes _____ No
 If yes, please circle which allergy symptoms you have:

Sneezing
 Itchy Nose
 Itchy/runny/watery eyes
 Itchy throat
 Itchy ears
 Runny nose

Do you have asthma? _____ Yes _____ No

Do you have migraine headaches? _____ Yes _____ No

Nose and sinus symptoms: Do you have any of the following symptoms? If yes, please rate on a scale of 1 (mild) to 5 (severe).

Nasal blockage or stuffiness	1	2	3	4	5
Postnasal drip	1	2	3	4	5
Discolored nasal drainage	1	2	3	4	5
Nasal bleeding	1	2	3	4	5
Ear fullness	1	2	3	4	5
Sinus infections	1	2	3	4	5
Sore throat	1	2	3	4	5
Headache or facial pain	1	2	3	4	5
Halitosis (bad breath)	1	2	3	4	5
Snoring	1	2	3	4	5
Cough	1	2	3	4	5
Tooth pain	1	2	3	4	5

MEDICAL HISTORY: We would like to have a thorough knowledge of your medical history. With this in mind, please check "yes" if you have EVER had a problem with any of the areas listed below, and "no" if you have not.

General	yes	no
Arthritis		
Asthma		
Diabetes		
Easy bruising/bleeding		
Gastritis/Peptic Ulcer Disease		
High blood pressure		
Kidney disease		
Liver disease/Hepatitis		
Lung disease, including pneumonia		
Meningitis		
Seizures		
Tuberculosis		
Ulcer, other gastrointestinal disease		
Cardiopulmonary		
Heart murmur		
Palpitations		
Chest pain (angina)		
Shortness of breath		
Wheezing		
Chest tightness		
Heart arrhythmias		
Mitral valve prolapse		
Heart attack		
Eyes		
Recent change in vision		
Double vision		
Clouded vision		
Cataracts		
Glaucoma		
Endocrine		
Heat/cold intolerance		
Excessive thirst		
Thyroid problems		
Psychological		
Depression		
Other		

Do you smoke? ___ no ___ yes If so, how much?

If you smoked in the past, when did you quit?

Do you drink alcohol? ___ no ___ yes If so, how much?

FAMILY HISTORY:

Please circle all that apply to your family members.

- Allergy
- Sinus Disease
- Immunodeficiency
- Cystic Fibrosis
- Bleeding Disorder
- Asthma
- High Blood Pressure
- Heart Disease
- Diabetes
- Cancer

SOCIAL HISTORY:

Please state your current occupation: _____

Please state your marital status: _____

Have you had any recent changes in your home or work environment? Please describe.

Copyright© 2003
Daniel G. Becker, M.D.

Email: beckermailbox@aol.com