

*Dean P. Lyons, M.D.
Ear, Nose & Throat Specialist
Facial & Plastic Reconstructive Surgery*

NEW PATIENT MEDICAL HISTORY

PATIENT NAME: _____ DATE: _____

PRIMARY CARE PHYSICIAN: _____

WHAT IS THE REASON FOR TODAY'S VISIT? _____

WHEN DID THIS PROBLEM START? _____

WHERE IS THE PROBLEM/PAIN LOCATED? _____

WHAT IS THE SEVERITY OF THIS PROBLEM? (circle one) (minor) 1 2 3 4 5 (severe)

WHAT PRIOR TREATMENT HAVE YOU RECEIVED FOR THIS PROBLEM? _____

YOUR MEDICAL HISTORY: (circle all that apply)

High Blood Pressure	Heart Attack/Angina	Arrhythmia/Murmur	Diabetes	Stroke
Allergic Rhinitis	COPD (lung disease)	Reflux/GERD	Migraines	Asthma
Anesthesia Problems	Kidney Disease	HIV/AIDS/Hepatitis	Cancer/Skin Cancer	

Other medical problems not listed: _____

SOCIAL HISTORY:

Smoking: ___Never Cigarettes per day: ___ When did you start? ___ When did you quit? ___
Alcohol: ___Never ___Occasional ___Daily

DOES ANYONE IN YOUR FAMILY (BLOOD RELATIVE) HAVE A HISTORY OF?

Bleeding Disorders	Hearing Loss	High Blood Pressure	Heart Disease
Allergies	Asthma	Cancer	Migraines

LIST ALL CURRENT MEDICATIONS:

WHAT MEDICATIONS ARE YOU ALLERGIC TO? _____

MAJOR SURGERIES AND HOSPITALIZATIONS: (please list date, type of surgery, and reason)

REVIEW OF SYSTEMS (please circle all that apply)

Constitutional: fever weight loss chills night sweats

Eyes: pain pressure double vision glaucoma cataracts

Ears: pain tinnitus (ringing) blockage hole in eardrum
Firearm use noise exposure hearing loss imbalance vertigo

Nose: hay fever cat allergy lawn mowing allergy trauma
stuffy nose runny nose sinus infections

Throat: tonsillitis throat pain hoarseness swallowing trouble

Cardiac: irregular heartbeats murmur chest pain swollen ankles

Respiratory: shortness of breath cough (daytime/nighttime)

Gastrointestinal: nausea constipation diarrhea blood in stool

Musculoskeletal: TMJ problems low back pain neck arthritis joint surgery

Skin: rash unusual moles

Neurology: seizures strokes chronic headaches

Lymph: enlarged lymph nodes

_____CHECK HERE IF ALL ARE NEGATIVE

Please list any other problems of concern you think Dr. Lyons should be aware of: _____

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT: _____

