DECATUR ENT ASSOCIATES
1218 13TH Avenue, S.E., Decatur · AL 35601
Phone (256) 355-6200

INITIAL HISTORY FORM

RENAISSANCE FACIAL PLASTIC SURGERY
1218 13TH Avenue, S.E. · Decatur, AL 35601
Phone (256) 351-2000 · 1 (866) 239-FACE

Name ____ **Age** ____________ **D.O.B.**______________________

Reason for Visit ____________________________________ **Duration** ________________ **Today's Date**__________

PLEASE CHECK THE PROBLEMS THAT APPLY TO YOU (No checks mean no problems)

REVIEW OF SYSTEMS

Constitutional:	□fever	□chill		
Eyes:	□excessive tearing	□itchy eyes		
Cardiovascular:	□irregular heart	□syncope(fainting)	□lightheadedness	□high blood pressure
Respiratory:	□shortness of breath	□wheezing	□cough	□coughing up blood
Gastrointestinal:	□heart burn	□irritable bowel		
Genitourinary:	□Urinary hesitancy	□prostate trouble		
Integument:	□skin rash	□itching skin		
Neurologic:	□incoordination	□tingling / numbness	□loss of balance	□loss of consciousness
Musculoskeletal:	□joint pain	□limitation of motion	□muscular weakness	
Psychiatric:	□anxiety	□depression		
Heme-Lymph:	□easy bleeding	□easy bruising		
Allergic-Immunology:	□allergic dermatitis	□frequent illness		

PATIENT HISTORY:

____Glaucoma ____High Blood Pressure
____Seizures ____Heart Attack
____Arthritis ____Heart Failure
____Asthma ____Stroke
____Ulcers ____Mitral Valve Prolapse
____Hepatitis ____Rheumatic Fever
____Diabetes ____Kidney/Bladder
____Thyroid ____Migraine
____Other____
____

PREVIOUS SURGERY: (List ALL Surgery)__________________
____
____
____

MEDICATIONS NOW TAKING: (including Aspirin or over-the-counter medicines)
Type & Date:____
____
____
____
____
____
____
____
____

DRUG ALLERGIES:_____________________________________
____

FAMILY PHYSICIAN:___________________________________
REFERRING PHYSICIAN:_______________________________

PERSONAL HISTORY:

Tobacco Use: _______Yes ________No
How Often __________ **Amount Used** ____________
Age Started__________ **Age Stopped** ____________

Alcohol Use: _______Yes ________ No
How Often ________ **Amount Consumed**_________
Age Started ________ **Age Stopped** ____________

OCCUPATION:________________________________

PHARMACY OF CHOICE:________________________
____

FAMILY HISTORY:

_____Hearing Loss
_____Allergy
_____Heart Disease/Blood Pressure
_____Cancer
_____Anesthesia Problem
_____Bleeding Disorders
_____Muscular Dystrophy
_____Other__________________________________

Mother **Alive**_______ **Deceased**_______
Cause___________________________
Father **Alive**_______ **Deceased**_______
Cause___________________________

Are you receiving any Hospice or Home Heath Care?
_____Yes ______No

Updated______________ **Updated**_____________
Updated______________ **Updated**_____________