

OTOSURGICAL GROUP MEDICAL CLINIC, INC.

2080 CENTURY PARK EAST, SUITE 1700, LOS ANGELES, CA 90067 (310)201-0717 FAX (310)201-9665

PATIENT'S NAME: \_\_\_\_\_ DATE OF VISIT: \_\_\_\_/\_\_\_\_/\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ OCCUPATION \_\_\_\_\_

REASON FOR VISIT: \_\_\_\_\_

CURRENT MEDICINES/DOSES: 1. \_\_\_\_\_
2. \_\_\_\_\_ 5. \_\_\_\_\_
3. \_\_\_\_\_ 6. \_\_\_\_\_
4. \_\_\_\_\_ 7. \_\_\_\_\_

ALLERGIES TO MEDICINES:
1. \_\_\_\_\_
2. \_\_\_\_\_

PLEASE LIST ALL PRIOR MAJOR ILLNESSES/SURGERIES (with years)

Illnesses/Injuries 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_
Hospitalizations 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_
Operations 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

FAMILY HISTORY (please check) \_\_\_ Heart Disease \_\_\_ Diabetes \_\_\_ Cancer \_\_\_ Other \_\_\_\_\_

Which family member? \_\_\_\_\_

Do you drink soda/coffee/tea? \_\_\_ No, never \_\_\_ No, but I used to \_\_\_ Yes ~ Cups/Drinks per day? \_\_\_\_\_
Do you drink alcohol? \_\_\_ No, never \_\_\_ No, but I used to \_\_\_ Yes ~ How many drinks? \_\_\_\_/day or wk?
Do you smoke? \_\_\_ No, never \_\_\_ No, but I used to \_\_\_ Yes ~ Packs per day? \_\_\_x\_\_\_ years
Do you use illicit drugs? \_\_\_ No, never \_\_\_ No, but I used to \_\_\_ Yes ~ Which? \_\_\_\_\_

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (circle Y or N)

Table with 3 columns: CONSTITUTIONAL, CARDIOVASCULAR, GENITOURINARY; EYES, GASTROINTESTINAL, SKIN; EAR/NOSE/THROAT, ENDOCRINE, MUSCULOSKELETAL; NEUROLOGIC, RESPIRATORY, PSYCHIATRIC; HEMATOLOGY, OTHER. Rows list various medical conditions with Y/N options.

If YES to any of the above, please explain: \_\_\_\_\_