Naugatuck Valley ent Ear, Nose & Throat Associates LLC

Surgeon's Name: _____

Today's Date: _____ FACILITY: _____

Name: _____Age: ____ Height: _____ Weight: _____

Medical Doctor's:_____ Last Seen: _____

Cardiologist (if applicable): _____ Last Seen: _____

Please answer the following questions to the best of your ability. Any other information you'd like to share regarding your health history or comments, please elaborate at the end of the questionnaire.

Do you have, or have you ever had, the following conditions, illnesses or symptoms?
PLEASE CIRCLE YOUR ANSWER

Neurological:

Stroke	Yes No
Mini Strokes	Yes No
Seizures	Yes No
Migraines	Yes No
Fainting	Yes No
Depression	Yes No
Multiple Sclerosis	Yes No
Developmental Disability	Yes No
Explain:_____	

Respiratory:

Asthma	Yes No
Shortness of Breath	Yes No
Emphysema	Yes No
Tuberculosis	Yes No
Pneumonia	Yes No
Chronic Chough	Yes No
Sleep Apnea	Yes No
CPAP machine	Yes No
Do you smoke?	Yes No
How much?_____ PPD	
Recent Cold or Flu?	Yes No

Cardiac:

High Blood Pressure	Yes No
Heart Attack? Date:_____	Yes No
Angina/ Chest Pain	Yes No
Palpitations	Yes No
Irregular Heart Beat	Yes No
Hear Murmur	Yes No
Heart Bypass Surgery	Yes No
Date:_____	
Cardiac Angioplasty	Yes No
Date: _____	
Pacemaker/ Defibrillator	Yes No
Date:_____ Where:_____	
Congestive Heart Failure	Yes No

Pediatric Patients ONLY:

Was child born prematurely	Yes No
How many weeks?_____	
Any problems noted at birth?	Yes No
_____	

Liver/Gastrointestinal:

Hepatitis	Yes No
Jaundice	Yes No
Liver Disease	Yes No
Cirrhosis	Yes No
Hiatal Hernia	Yes No
Heartburn	Yes No
Acid Reflux	Yes No
Do you drink alcohol?	Yes No
How much? _____	
Do you use Recreational drugs?	Yes No
How often? _____	

Hematological/ Oncological:

Clotting Disorders	Yes No
Anemia	Yes No
Blood Clots in legs or lungs	Yes No
History of cancer? Where? _____	
Radiation Therapy?	Yes No
Chemotherapy?	Yes No

Urinary:

Kidney Disease	Yes No
Kidney Stones	Yes No
Dialysis	Yes No

Endocrine:

Diabetes	Yes No
Hypothyroidism	Yes No
Hyperthyroidism	Yes No

Allergies: please list _____
_____

Please list present medications: _____
_____
_____

Please list prior surgeries: _____
_____

Have you had an anesthetic complication or is there a family history of anesthesia complications?_____
_____
_____