MICHAEL SETZEN, MD, FACS, FAAP

Nasal & Sinus Surgery • Facial Plastics-Rhinoplasty/Botox/Fillers
Pediatric ENT • Snoring/Sleep Apnea • Reflux/Swallowing/Voice • Laser
Hearing & Balance • Head & Neck • FEESST/Stroboscopy • In-office CT

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MEDICAL INFORMATION SHEET

Date: _____

Patient Name: _____ DOB: _____ Age: _____
Address: _____
Height: _____ Weight: _____ Gender: _____
Main Complaint: _____

History of Main Complaint-Describe: _____

Medications: _____

Medical History:		Yes	No
Heart:	High Blood Pressure	☐	☐
	Arrhythmia	☐	☐
	Heart Attack	☐	☐
	Angina	☐	☐
Respiratory:	Asthma	☐	☐
	Shortness of Breath	☐	☐
	Sleep Apnea	☐	☐
Neurology:	Headaches	☐	☐
	Migraines	☐	☐
Endocrine:	Thyroid Problems	☐	☐
	Diabetes	☐	☐
Eyes:	Visual Problems	☐	☐
	Kidney Disease	☐	☐
GI Disease:	Reflux	☐	☐
	Swallowing Problems	☐	☐
	Weight Loss	☐	☐
Cancer History:			
	Where: _____	☐	☐
	When: _____		
	What Kind: _____		
Skin Disease:			
	What Kind: _____		
Infectious Disease:	Hepatitis	☐	☐
Musculoskeletal:	Arthritis	☐	☐
Hematologic:	Bleeding Disorder	☐	☐
Surgical History:	Type of Operation	☐	☐
	When: _____		
	_____		

Social History:	Yes	No
Do you or did you smoke?	☐	☐
#/Packs a day _____		
Do you or did you drink?	☐	☐
# of drinks a day _____		
Are you pregnant?	☐	☐
Family Medical History:		
Cancer	☐	☐
High Blood Pressure	☐	☐
Heart Problems	☐	☐
Hepatitis	☐	☐
Bleeding Problem	☐	☐
Diabetes	☐	☐
Seizures/Epilepsy	☐	☐
Asthma	☐	☐

Please Check Yes or No:	Yes	No
Seasonal Allergies	☐	☐
Allergy to Medications, please list	☐	☐

_____
_____
_____

Other/Miscellaneous: _____
_____
_____
_____
_____
_____

Patient/Guardian Signature: _____ Date: _____

Pharmacy: Name: _____ Phone: _____
Address: _____ Fax: _____