

Dr. *Nancy* BECKER

EARS, NOSE & THROAT ALLERGY THERAPY FACIAL PLASTIC SURGERY

1427 Jefferson, Suite 101, Enumclaw, WA 98022 Office: 360.825.4466 Fax: 360.825.2064 www.drnancybecker.com

Youth History & System Review (2 pages)

Patient Name

--	--	--

Last

First

Middle

Age _____ **Weight** _____ Male Female

Surgeries/year _____ / _____ / _____

Surgeries/year _____ / _____ / _____

Surgeries/year _____ / _____ / _____

Complications of surgery _____

Current medical problems _____

Current medications _____

Allergies / Reactions _____

Current on shots? No Yes **Breast fed?** No Yes **In daycare?** No Yes

Caffeine use? No Yes If yes, amount _____

Passive (second hand) smoke exposure? No Yes If yes, frequency _____

Attending school? No Yes **School** _____

Father's health (if deceased, cause of death) _____

Mother's health (if deceased, cause of death) _____

Siblings with significant medical problems Yes No _____

Check all that apply to your immediate family: parents/grandparents/siblings

- diabetes asthma high blood pressure stroke bleeding disorders heart problems
- cancer ear surgery early hearing loss hayfever

I certify that this history form is filled out completely and accurately. I have answered all questions truthfully and to the best of my knowledge.

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

I have reviewed the above information with the patient.

STAFF SIGNATURE _____ **DATE** _____

Dr. *Nancy* BECKER

EARS, NOSE & THROAT  ALLERGY THERAPY  FACIAL PLASTIC SURGERY

1427 Jefferson, Suite 101, Enumclaw, WA 98022  Office: 360.825.4466  Fax: 360.825.2064  www.drnancybecker.com

Reason for appointment _____ Consult requested by _____

Please check any boxes that apply. Mark with “?” if you are unsure and it will be reviewed with you.

<p><u>EARS</u></p> <p><input type="checkbox"/> pain</p> <p><input type="checkbox"/> drainage</p> <p><input type="checkbox"/> hearing loss</p> <p><input type="checkbox"/> ringing/head noise</p> <p><input type="checkbox"/> dizziness/imbalance</p> <p><input type="checkbox"/> infection</p> <p><input type="checkbox"/> none of the above</p>	<p><u>NOSE</u></p> <p><input type="checkbox"/> runny</p> <p><input type="checkbox"/> stuffy</p> <p><input type="checkbox"/> bloody</p> <p><input type="checkbox"/> nasal obstruction</p> <p><input type="checkbox"/> sinusitis</p> <p><input type="checkbox"/> infection</p> <p><input type="checkbox"/> none of the above</p>	<p><u>THROAT</u></p> <p><input type="checkbox"/> hoarse/sore</p> <p><input type="checkbox"/> snoring</p> <p><input type="checkbox"/> difficulty swallowing</p> <p><input type="checkbox"/> voice change/issues</p> <p><input type="checkbox"/> post nasal drainage</p> <p><input type="checkbox"/> productive cough</p> <p><input type="checkbox"/> none of the above</p>	<p><u>ALLERGY</u></p> <p><input type="checkbox"/> hives</p> <p><input type="checkbox"/> itching</p> <p><input type="checkbox"/> red itchy eyes</p> <p><input type="checkbox"/> sneezing</p> <p><input type="checkbox"/> none of the above</p>
<p><u>CARDIOVASCULAR</u></p> <p><input type="checkbox"/> chest pain</p> <p><input type="checkbox"/> rapid or irregular heartbeat</p> <p><u>CONSTITUTIONAL</u></p> <p><input type="checkbox"/> fatigue</p> <p><input type="checkbox"/> fever</p> <p><input type="checkbox"/> night sweats</p> <p><input type="checkbox"/> weight gain</p> <p><u>ENDOCRINE</u></p> <p><input type="checkbox"/> changes in growth</p> <p><input type="checkbox"/> changes in hair</p> <p><input type="checkbox"/> heat/cold intolerance</p> <p><u>EYES</u></p> <p><input type="checkbox"/> blurred vision</p> <p><input type="checkbox"/> double vision</p> <p><input type="checkbox"/> none of the above</p>	<p><u>GASTROINTESTINAL</u></p> <p><input type="checkbox"/> appetite, weight change</p> <p><input type="checkbox"/> blood in stool</p> <p><input type="checkbox"/> bowel problems</p> <p><input type="checkbox"/> canker sores</p> <p><input type="checkbox"/> diarrhea</p> <p><input type="checkbox"/> heartburn</p> <p><u>GENITOURINARY</u></p> <p><input type="checkbox"/> difficulty urinating</p> <p><input type="checkbox"/> frequent urination</p> <p><u>HEMATOLOGIC</u></p> <p><input type="checkbox"/> anemia</p> <p><input type="checkbox"/> bleed easily</p> <p><input type="checkbox"/> bruise easily</p> <p><input type="checkbox"/> joint pain</p> <p><input type="checkbox"/> lymph node swelling</p> <p><input type="checkbox"/> none of the above</p>	<p><u>MUSCULOSKELETAL</u></p> <p><input type="checkbox"/> broken nose</p> <p><input type="checkbox"/> head injury</p> <p><input type="checkbox"/> injuries</p> <p><input type="checkbox"/> jaw pain</p> <p><input type="checkbox"/> muscle pain</p> <p><input type="checkbox"/> neck injury</p> <p><input type="checkbox"/> neck pain</p> <p><u>NEUROLOGIC</u></p> <p><input type="checkbox"/> clumsiness</p> <p><input type="checkbox"/> convulsions</p> <p><input type="checkbox"/> headaches</p> <p><input type="checkbox"/> memory problems</p> <p><input type="checkbox"/> migraines</p> <p><input type="checkbox"/> numbness</p> <p><input type="checkbox"/> seizures</p> <p><input type="checkbox"/> none of the above</p>	<p><u>PSYCHIATRIC</u></p> <p><input type="checkbox"/> depression</p> <p><input type="checkbox"/> hallucinations</p> <p><input type="checkbox"/> mood changes</p> <p><input type="checkbox"/> sleep disturbances</p> <p><input type="checkbox"/> stress</p> <p><u>RESPIRATORY</u></p> <p><input type="checkbox"/> coughing blood</p> <p><input type="checkbox"/> painful breathing</p> <p><input type="checkbox"/> shortness of breath</p> <p><input type="checkbox"/> wheezing</p> <p><u>SKIN</u></p> <p><input type="checkbox"/> skin growths/moles</p> <p><input type="checkbox"/> skin ulcers/blemishes</p> <p><input type="checkbox"/> slow healing wounds</p> <p><input type="checkbox"/> very dry skin</p> <p><input type="checkbox"/> none of the above</p>