HARVARD MEDICAL SCHOOL MASSACHUSETTS EYE AND EAR INFIRMARY

SINUS CENTER MEDICAL INFORMATION FORM

Benjamin S. Bleier, MD
Nicolas Y. Busaba, MD
Stacey T. Gray, MD
Eric H. Holbrook, MD

Date: _____

Name: DOB / / Age:

Address: City/State/Zip

Home Phone ( ) Work Phone ( )

Employment:

Emergency Contact (Name, Relationship, Phone #):

Primary Care Physician(PCP):

PCP Address and Phone Number:

Were You Referred? YES/NO Name of Referring Physician:

Referring Physician(Address, Phone #):

WHAT IS YOUR PRESENT PROBLEM? _____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

WHAT TREATMENTS HAVE YOU TRIED? _____

Please answer the following questions and check all that apply:

Do you have any allergies(Medications, Latex, etc..)? _____

What are your current medications?

Do you have a history of:

☐Diabetes	☐Stroke	☐Heart Attack	☐Heart Disease	☐High Blood Pressure
☐Blood Clots	☐Chemotherapy	☐Cancer	☐Radiation	☐Immune Problems
☐Bleeding	☐Ulcer	☐Lung Disease	☐AIDS/HIV	☐Hepatitis

Do you have any other medical problems?

Have you had any surgeries(Please list month/year)?

Please Complete and Sign Reverse Side ➡

Prior to your *FIRST* sinus infection, did you take antibiotics for any reason *BESIDES* your sinuses(Please circle)?

YES NO N/A

If *YES*, how much time passed between the antibiotics and your first sinus infection(Please circle all that apply)

1-3months 3-6months 6months-1year 1-2years Over 2 years

What was the reason you were given antibiotics? _____

What was the name of the antibiotic? _____

Do you smoke? YES/NO Packs/day? _____ Have you ever smoked? YES/NO

Do you drink alcohol? YES/NO Drinks/week? _____

Have you experienced any of the following?

EYES	☐Blurred Vision ☐Painful Eyes ☐Light Irritation ☐Other
EARS, NOSE, THROAT	☐Blocked Nose ☐Post Nasal Drip ☐Runny Nose ☐Neck Masses ☐Mouth Sores/Pain ☐Difficulty Breathing ☐Difficulty Swallowing ☐Pressure in Ears ☐Ringing in Ears ☐Hearing Loss ☐Vertigo ☐Other
CARDIOVASCULAR(HEART)	☐Palpitations ☐Chest Pain ☐Shortness of Breath ☐Other
RESPIRATORY(LUNGS)	☐Wheezing ☐Shortness of Breath ☐Cough ☐Other
GASTROINTESTINAL	☐Constipation ☐Diarrhea ☐Reflux ☐Other
GENITOURINARY	☐Urinary Hesitancy or Pain ☐Urination at Night ☐Other
MUSCULOSKELETAL	☐Soreness ☐Weakness ☐Cramping ☐Other
SKIN	☐Itching ☐Lesions ☐Rashes ☐Bleeding ☐Other
NEUROLOGICAL	☐Numbness ☐Weakness ☐Dizziness ☐Other
PSYCHIATRIC	☐Mood Swings ☐Anxiety ☐Depression ☐Stress ☐Other
ENDOCRINE	☐Hot Flashes ☐Hair Loss/Growth ☐Heat ☐Cold ☐Other
HEMATOLOGY	☐Night Sweats ☐Bleeding/Bruising ☐Clotting ☐Other
ANESTHESIA	☐Malignant Hyperthermia ☐Nausea ☐Chipped/Loose Teeth ☐Other

Patient Signature _____ Date _____