



LAWRENCE MARTIN MD, FACS

COSMETIC AND RECONSTRUCTIVE FACIAL PLASTIC SURGERY
ENT - HEAD AND NECK SURGERY

Diplomate of the American Board of Otolaryngology-Head & Neck Surgery
Diplomate of the American Board of Facial Plastic and Reconstructive Surgery

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Confidential Health History for patient: _____ (please print)

LIST ALL MEDICATIONS (Including over-the-counter, vitamins, aspirin, etc)

ALLERGIES: YES NO If yes, please list _____

YOUR PAST MEDICAL/SURGICAL HISTORY

Has the patient ever had any surgery and/or been hospitalized? NO YES If yes, please fill in below.

Year	Facility	Reason/Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any other medical illnesses and/or problems that we should know about? NO YES If yes, please fill in below.

Year	Illness/Problem	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

Health habits: Tobacco _____ Alcohol _____ Drugs _____

Height _____ Weight _____ Sleep, hours per night _____

SYSTEM REVIEW:

Circle NO if none, otherwise check those that apply.

- GENERAL: NO Significant weight change Fevers
- HEM/ONC: NO Bleeding or bruising problem Leukemia/lymphoma
 NO Any known cancer not otherwise noted? If so, what kind? _____
- ALL/IMM: NO Hay fever Environmental Allergy Food Allergy Latex Allergy
- INF DZ: NO HIV and/or AIDS Hepatitis Weakened Immune System
- ENDO: NO Thyroid problems Thyroid Nodule Diabetes
- CV: NO High blood pressure Irregular heartbeat Pacemaker
 NO Heart attack Heart Disease Heart Surgery
 NO Ever been told you need antibiotics before any dental procedure?
- RESP: NO Emphysema Sleep apnea COPD Asthma Tuberculosis
- PSYCH: NO Chemical dependency Alcoholism Psychiatric illness
- GU: NO Kidney disease Dialysis Renal insufficiency
- NEURO: NO Headaches Stroke TIA Migraines
- OPHTH: NO Loss of vision Double vision Glaucoma
- ENT: NO Speech/language delay/problems Sinus problems Ear pain Vertigo
 NO Prior Head/Neck/Face trauma or surgery _____
 NO Prior Cosmetic surgery

FAMILY HISTORY: Do any of the patient's blood relatives have/had any of the following:

Please check all that apply: Bleeding or bruising problems Problems with anesthesia Hearing loss Asthma
 Thyroid disease Cancer Autoimmune disease Other _____

Patient/Guardian signature _____ Date _____