

# LOS ANGELES SINUS INSTITUTE

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**PLEASE PRINT**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**REASON FOR VISIT:** \_\_\_\_\_

<b>CURRENT MEDICINES:</b>	1. _____	<b>ALLERGIES TO MEDICINES:</b>
2. _____	3. _____	1. _____
4. _____	5. _____	2. _____
6. _____	7. _____	

**PLEASE LIST ALL PRIOR MAJOR ILLNESSES/SURGERIES (WITH YEARS)**

Illnesses/Injuries: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Hospitalizations: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Operations: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**FAMILY HISTORY:**  Heart Disease  Diabetes  Cancer  Sinusitis  Allergies  Other \_\_\_\_\_

Which family member? \_\_\_\_\_

Do you drink soda/coffee/tea?  No, never  No, but I used to  Yes ~ Cups/Drinks per day? \_\_\_\_\_

Do you drink alcohol?  No, never  No, but I used to  Yes ~ How many drinks? \_\_\_\_/day or wk?

Do you smoke?  No, never  No, but I used to  Yes ~ Packs per day? \_\_\_\_\_x\_\_\_\_\_ years

Do you use illicit drugs?  No, never  No, but I used to  Yes ~ Which? \_\_\_\_\_

**HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (circle Y or N)**

<b>CONSTITUTIONAL</b>		<b>CARDIOVASCULAR</b>		<b>GENTOURINARY</b>	
weight gain/loss(>15lbs)	Y N	heart attack	Y N	frequent urination	Y N
constant night sweats	Y N	high blood pressure	Y N	prostate problems n/a	Y N
fatigue	Y N	heart murmur	Y N	pain with urination	Y N
<b>EYES</b>		<b>GASTROINTESTINAL</b>		<b>SKIN</b>	
double vision	Y N	diarrhea	Y N	past skin cancer	Y N
glaucoma	Y N	heartburn	Y N	past radiation therapy	Y N
<b>EAR/NOSE/THROAT</b>		<b>ENDOCRINE</b>		<b>MUSCULOSKELETAL</b>	
hearing loss	Y N	diabetes	Y N	arthritis	Y N
ear pain	Y N	thyroid disease	Y N	back pain	Y N
ringing in ears	Y N	autoimmune disease	Y N	<b>RESPIRATORY</b>	
balance problems	Y N	<b>NEUROLOGIC</b>		asthma/emphysema	Y N
hearing aid	Y N	headaches	Y N	chronic cough	Y N
difficulty breathing	Y N	seizures	Y N	Tuberculosis	Y N
nosebleeds	Y N	stroke	Y N	<b>PSYCHIATRIC</b>	
nasal drainage	Y N	<b>HEMATOLOGY</b>		anxiety	Y N
sinus problems	Y N	bruise easily	Y N	depression	Y N
snoring	Y N	anemia	Y N	sleep problems	Y N
voice changes	Y N	excessive bleeding	Y N	<b>OTHER</b> _____	

**If YES to any of the above, please explain:** \_\_\_\_\_

Reviewed by: \_\_\_\_\_, MD