Alyeska Center for Facial Plastic Surgery/ENT
3831 Piper St Ste S-433
Anchorage, AK 99508

_____ _____
Name Date of Visit

How did you hear about us: _____
Reason for Visit: _____

Medical History
Do you now or have you ever had a history of:

1. Abnormal bleeding or a bleeding disorder	□Yes □ No
2. Anesthetic complications	□Yes □ No
3. Diabetes	□Yes □ No
4. Heart disease (heart attack, chest pains, irregular heartbeat, congestive failure)	□Yes□ No
5. Lung disease	□ Yes□ No
6. Wound healing complications	□ Yes□ No
7. Keloids or poor scarring	□ Yes□ No
8. Heart murmur requiring preventative antibiotics	□ Yes□ No
9. Radiation treatments	□ Yes□ No
10. Tuberculosis	□ Yes□ No
11. Hepatitis or liver disease	□ Yes□ No
12. Gastric or peptic ulcers	□ Yes□ No
13. Stroke	□ Yes□ No
14. Cancer	□ Yes□ No
15. Kidney disease	□ Yes□ No
16. Psychiatric illness	□ Yes□ No
17. Implants or artificial devices (i.e. heart valve, joints, lens, pacemaker)	□ Yes□ No
18. Eye disease (glaucoma, retinal detachment, cataracts)	□ Yes□ No
19. High blood pressure	□ Yes□ No
20. Inflammatory, or autoimmune disease (lupus, wegener's, sarcoid, MS)	□ Yes□ No
21. HIV or AIDS	□ Yes□ No
22. Family history of abnormal bleeding or anesthetic complications	□ Yes□ No
23. Other medical problems	□ Yes□ No
24. Do you have any religious reason why you would not accept blood products	□ Yes□ No
25. Have you or anyone in your family been treated for a MRSA skin infection	□ Yes□ No
26. Do you have history of contracting COVID -19	□ Yes□ No
27. Are you vaccinated for COVID -19	□ Yes□ No

If you answered yes to any of the above, please provide details below: _____
_____
_____

List all prescriptive and over the counter medications:

List all ALLERGIES to MEDICATIONS:

(w: patienthistoryinfo)

******PLEASE COMPLETE OTHER SIDE******

NAME: _____ DATE OF BIRTH: _____

List all prior SURGERIES and HOSPITALIZATIONS:

Family and Social History:

Occupation: _____

Tobacco use (cigarettes, cigars, pipes, chew, snuff):	Years of use	Packs per day	Year quit
	_____	_____	_____
Do you consume alcoholic beverages regularly?			☐ Yes ☐ No
Do you use illicit or addictive drugs (cocaine, marijuana, etc.)			☐ Yes ☐ No
If female, is there a chance you might be pregnant			☐ Yes ☐ No

Please list any illnesses that run in your family:

Check any of the following that you are currently or have previously experienced:

General		Eyes	
Rashes/bruising/skin problems	☐ Now ☐ Past	Clouded vision	☐ Now ☐ Past
Recent weight loss or gain	☐ Now ☐ Past	Dry eyes	☐ Now ☐ Past
Fatigue	☐ Now ☐ Past	Double vision	☐ Now ☐ Past
Fever/chills/night sweats	☐ Now ☐ Past		
		Ears	
Sleep Disturbance		Ringing	☐ Now ☐ Past
Loud snoring	☐ Now ☐ Past	Hearing loss	☐ Now ☐ Past
Excessive sleepiness	☐ Now ☐ Past	Dizziness/vertigo	☐ Now ☐ Past
Breathing stops during sleep	☐ Now ☐ Past	Pain	☐ Now ☐ Past
Wake up feeling unrested	☐ Now ☐ Past	Drainage	☐ Now ☐ Past
Cardiopulmonary		Mouth/Throat	
Heart murmur	☐ Now ☐ Past	Dryness	☐ Now ☐ Past
Palpitations	☐ Now ☐ Past	Hoarseness	☐ Now ☐ Past
Chest pain	☐ Now ☐ Past	Choking	☐ Now ☐ Past
Shortness of breath	☐ Now ☐ Past	Difficulty swallowing	☐ Now ☐ Past
Wheezing	☐ Now ☐ Past	Lumps in neck	☐ Now ☐ Past
Chest tightness	☐ Now ☐ Past	Painful swallowing	☐ Now ☐ Past
Nervous System		Nose	
Numbness	☐ Now ☐ Past	Nasal congestion	☐ Now ☐ Past
Tingling	☐ Now ☐ Past	Nasal drainage	☐ Now ☐ Past
Fainting	☐ Now ☐ Past	Facial pressure/pain	☐ Now ☐ Past
Weakness	☐ Now ☐ Past	Nasal bleeding	☐ Now ☐ Past
Endocrine		Gastrointestinal	
Heat/Cold intolerance	☐ Now ☐ Past	Indigestion/heartburn	☐ Now ☐ Past
Excessive thirst	☐ Now ☐ Past	Nausea/vomiting	☐ Now ☐ Past
Change in shoe/hand size	☐ Now ☐ Past	Change in stool color	☐ Now ☐ Past
		Diarrhea/constipation	☐ Now ☐ Past
		Abdominal pain	☐ Now ☐ Past

(w: patienthistoryinfo)