FORT STREET ENT REGISTRATION FORM

Patient Name: _____ **Birth Date:** _____ (m/d/yy)

Email: _____ **Family Doctor**: _____

(FOR SCHEDULING ONLY)

Please check all that apply

Allergies :		Alcohol Use :	Smoking :	Medications :
Penicillin ☐	Dust mites ☐	Non-Drinker ☐	Non-smoker ☐	Plavix ☐
Environmental ☐	Erythromycin ☐	Rarely ☐	Cigarettes ☐	Coumadin ☐
Cats/Dogs ☐	Adhesive ☐	0-5 drinks/wk ☐	Cigars ☐	Aspirin ☐
Pollen ☐	IV Contrast ☐	5-10 drinks/wk ☐	Cannabis ☐	Other :
Latex ☐	Other :	10+ drinks/wk ☐	Chewing ☐	(please list)
	_____		Tobacco	
			How much ?_____	

Metal Implants: ☐ No If **Yes** OR pacemaker/defibrillator, please describe: _____

Is there any possibility of metal in your eyes? ☐ No ☐ Yes

Past or present Illnesses:

Hypertension	☐ No	☐ Yes	
Diabetes	☐ No	☐ Yes	
Heart Disease	☐ No	☐ Yes	
COPD / Lung Disease	☐ No	☐ Yes	
Hepatitis	☐ No	☐ Yes	
Bleeding Disorders	☐ No	☐ Yes	
Sleep Apnea	☐ No	☐ Yes	If **Yes:** Do you use a CPAP Device ☐ Yes ☐ No

Other past or present illnesses: _____

Height:_____

Weight:_____

Surgical History (please describe):

Any difficulties with previous anesthetics: _____

Do you give consent to send information regarding your EAR, NOSE and THROAT condition to other health care professionals (IE: Physicians / GP / other specialists) when requested?

X _____ (If **YES**, please **SIGN**)