Mendy Maccabee, MD
Board Certified ENT and Allergy Care • FACS, FAAOA

In order for us to obtain a complete medical history and treat the medical condition that you are seeking help with; we need this form filled out as completely as possible.

Patient Full Name: _____ Birth Date: ____/____/_____ Gender: _____
Social Security Number: _____ Email: _____ Online medical access Y☐/ N☐
Reason for Today's Visit: _____Most Recent Occupation: _____

**Authorization of Release of Information**
I authorize the following person/people to discuss any necessary appointments, treatments, medications, test results, or anything else related to my medical care and/or appointment scheduling. I authorize the following person/people to bring in my child in for treatment and to discuss any appointments, treatments, medications, test results or anything else related to their medical care and/or appointment scheduling.

Name:_____ Relationship: _____Phone Number_____

Name:_____ Relationship: _____Phone Number_____

Who would you like us to contact in the case of an emergency?

Name:_____ Relationship: _____Phone Number_____

**List All Medications and Supplements You Are Taking (Or provide us with a list of your own)**

| Medication(s) | Dosage (mg, mcg, ml etc) | How Often (how many times /day) |
|---|---|---|
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| | | |
| | | |
| | | |
| | | |

(Please continue on back of form, if you need more room)

**Allergies to Medications: Yes☐ No☐ (If yes, please list below)**

| Medication(s) | Type of Reaction |
|---|---|
| | |
| | |
| | |
| | |

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Have you or any family member ever had an unusual reaction to anesthesia? Y☐ N☐ If yes, Who: ____
Type of Reaction:_____

**Past Medical History (Please check appropriate boxes)**

- ☐ Heart Attack
- ☐ Asthma
- ☐ Diabetes (Insulin Y☐ N☐ )
- ☐ Emphysema
- ☐ Coronary Artery Disease
- ☐ Bleeding Disorder
- ☐ Kidney Disorder
- ☐ Stroke
- ☐ Hepatitis
- ☐ Glaucoma
- ☐ Hypertension
- ☐ Heart Failure
- ☐ Arthritis
- ☐ Thyroid, Type: _____
- ☐ Cancer, Type: _____
- ☐ Other: _____

**Past Surgical History (Please check appropriate boxes and approximate date of procedure)**

- ☐ Ear Tubes_____
- ☐ Septoplasty_____
- ☐ Tonsillectomy _____
- ☐ Sinus Surgery_____
- ☐ Hernia_____
- ☐ Heart Bypass_____
- ☐ Cataracts_____
- ☐ Other_____
- ☐ Back/Neck_____
- ☐ Appendix_____
- ☐ Gall Bladder_____

**Family History (Please check appropriate boxes and list which immediate family it pertains to)**

- ☐ Strokes_____
- ☐ Diabetes_____
- ☐ Heart Disease_____
- ☐ Breast Cancer_____
- ☐ Thyroid disorders_____
- ☐ Allergies_____
- ☐ Asthma_____
- ☐ Hypertension_____
- ☐ Hearing Loss_____
- ☐ Cancer (type)_____
- ☐ Other_____

**Patient Signature: _____ Date: _____**