Dr. Artur Gevorgyan
Medicine Professional Corporation
Otolaryngologist- Head and Neck Surgeon
Specializing in Rhinology (nose and sinus disorders)
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New Patient Questionnaire (Please complete ALL pages and circle as required)

Patient Label

What is your profession/specialty/trade, if any? _____

Please, indicate if you have any of the following problems. If several choices provided, **please, *CIRCLE* those that apply** and **provide details** in the comment box	**Yes**	**No**	**Comments**
Heart, Circulation:			
Do you have chest pain or angina?			
Have you ever had a heart attack?			Date:
Have you ever had a stroke / TIA (mini-stroke)?			Date:
Are you being treated for high blood pressure?			
Do you have irregular pulse/palpitations/ arrhythmia/atrial fibrillation?			
Do you have a heart murmur/rheumatic fever/pacemaker?			
Do you take antibiotics before seeing a dentist?			
Have you ever had a pulmonary embolism or deep vein thrombosis (blood clots)?			
Do you have high cholesterol?			
Any other heart or circulation problems? Specify.			
Respiratory:			
Do you have asthma/bronchitis/emphysema/ COPD?			
Have you ever had pneumonia/tuberculosis?			
Do you have sleep apnea? If yes, are you on CPAP?			
Kidneys / Liver:			
Do you have any form of kidney disease?			
Are you on dialysis? If yes, how often?			
Have you had hepatitis/jaundice/liver disease?			When?
Joint problems, arthritis, connective/systemic disorders?			

Pre-Consultation Questionnaire

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	Yes	No	Comments
Endocrine:			
Are you diabetic: □ Insulin □ Pills □ Diet			
Do you have any thyroid problems?			
Do you have any other endocrine problems?			
Digestive/Stomach/Bowels:			
Do you have heartburn, acid reflux or a hiatus hernia?			
Do you have other digestive problems?			
Neurologic:			
Do you have any disease of nerves and muscles?			
Do you have epilepsy or seizures?			
Do you have depression, anxiety, psychosis?			
Cancer			
Have you been diagnosed or treated for cancer?			
Was the cancer treated with: □ Chemotherapy □ Radiation □ Surgery			
Have you had an organ/bone marrow/stem cell transplant? If yes, circle.			
Infectious:			
Do you have hepatitis B, C or HIV or any other significant infectious disease			
Blood:			
Do you have abnormal blood conditions?			
Have you been tested for sickle-cell disease?			
Have you had a reaction to a blood transfusion?			
Have you had a blood transfusion within the past 3 months? (If yes, where?)			
Anaesthesia:			
Had a problem with local/general/spinal/epidural anesthetic? If yes, describe:			
Has anyone related to you ever had a problem with an anesthetic?			
Do you or any member of your family have malignant hyperthermia or pseudocholinesterase deficiency?			
Please, list any other health problems:			

Please list any previous operations / surgeries	

Pre-Consultation Questionnaire

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Medications taken at home, include over the counter medications
Medication:

Allergies to medications and medical products	
If you do not have any allergies to medications, check □ No	
Are you allergic to latex or rubber? □ Yes □ No	
Drug Allergies	**Reactions / Symptoms**

	Yes	No	Comments
Have you ever smoked?			
How many cigarettes per day?			
For how many years?			
Have you permanently quit smoking? When did you quit?			
Alcohol use (number of drinks per week, include type)			
Do you use recreational drugs? Please describe.			

Date: _____

Signature: _____