GARRETT H. BENNETT, M.D., P.C.
Sinus and Nasal Surgery
115 East 61st Street, Suite 7C
New York, NY 10065-8183
(212) 980-2600 Fax: (212) 991-3009

PATIENT QUESTIONNAIRE

Patient Name: _____

Planned Procedure: _____

_____

_____

Please list ALL PAST SURGERIES:

_____

_____

_____

Anesthesia Problems: ☐ **Yes** ☐ **No**
If Yes, please list:

_____

Please list ALL MEDICATIONS, including DOSAGE:

_____

_____

_____

_____

_____

List any ALLERGIES (medications/food/inhalant):

_____

_____

Do you smoke? ☐ Yes ☐ No
Did you previously smoke? ☐ Yes ☐ No

Packs per day: _____ for _____ years Quit _____

Do you use recreational drugs? ☐ Yes ☐ No
Please list _____ How often _____

_____

Please list any non-prescription medications:
(e.g. cold tablets, vitamins)

_____

Please list any HERBAL:
(e.g. Ginkgo, Ginseng, St. John's Wort, Echinacea)

_____

_____

Weight: _____

Height: _____

Check any symptoms you have recently experienced:

☐ Weight Loss
☐ Fatigue
☐ Fever / Chills
☐ Other _____
☐ Weakness
☐ Pain (identify location):

Please list ALL YOUR medical conditions:

☐ None
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Bleeding Problems
☐ Bronchitis
☐ Chest Pain
☐ COPD
☐ Depression
☐ Excessive Bruising
☐ Glaucoma
☐ Heart Attack
☐ Heat / Cold Problems
☐ Hiatal Hernia
☐ High Blood Pressure
☐ Other: _____
☐ Kidney Disease
☐ Liver Disease
☐ Pacemaker
☐ Palpitations/Irregular heart
☐ Pneumonia
☐ Reflux
☐ Seizure
☐ Shortness of Breath
☐ Sleep Apnea
☐ Stroke
☐ TB
☐ Thyroid Disease
☐ Ulcer
☐ Urinary Problems
☐ ADD/ADHD
☐ Other _____

Family History of Medical Conditions:

☐ Asthma
☐ Cancer
☐ Diabetes
☐ Emphysema
☐ Heart
☐ High Blood Pressure
☐ Stroke
☐ Other: _____

Are you interested in a cosmetic consultation?

☐ Yes ☐ No

Date: _____ **Signature:** _____