Century Ear, Nose and Throat
Head and Neck Surgery

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PRE-OPERATIVE INFORMATION SHEET

Name _____

Do you have any allergies? Yes _____ No _____

If yes, to what? _____

DO YOU HAVE A HISTORY OF:

Heart disease Yes _____ No _____

Lung problems Yes _____ No _____

Liver disease Yes _____ No _____

Diabetes Yes _____ No _____

High blood pressure Yes _____ No _____

Bleeding tendencies Yes _____ No _____

Chest pains Yes _____ No _____

Breathing difficulties Yes _____ No _____

Do you smoke? Yes _____ No _____

If yes, how much per day _____

Do you drink? Yes _____ No _____

If yes, how much per day _____

Are there bleeding problems in your family? Yes _____ No _____

List any medication you are taking: _____

_____

Do you completely understand the operative procedure, the alternatives, risks, benefits, and the length of recovery? Yes _____ No _____