



Arnaldo A. Garro, M.D., F.A.C.S., F.I.C.S.

BOARD CERTIFIED OTOLARYNGOLOGIST

• Ear • Nose • Throat • Head & Neck Surgery • Endoscopic Sinus Surgery •

www.DrArnaldoGarro.com

(301) 868-8926

PATIENT REGISTRATION FORM

Please fill in all blank lines on these pages. If the question does not apply to you or the Patient write in the initials DNA (Does Not Apply). Thank you.

Patient's Name _____

Age _____ Date of Birth _____ Height _____ Weight _____

Briefly describe why you are here to see Dr. Garro today _____

When did your problems/symptoms first appear? _____

Have you seen any doctors for this problem? _____ If yes, who and when? _____

Did they do any special tests? If so what tests? _____

When and where were the tests done? _____

Who has referred you to our offices? _____

If you were not referred, How did you learn about us? _____

Have you ever been hospitalized? If yes, why, when, where? _____

<u>Previous surgeries (List)</u>	<u>Year</u>	<u>Hospital</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you a diabetic? _____ If yes are you controlled by insulin _____, Pills _____, or diet _____

How many years have you been diabetic? _____

Are you currently being treated for high blood pressure? _____ If yes, for how many years _____

What medications do you take for it? _____

Have you ever had hepatitis? _____ If yes, what type and when? _____

Have you ever been diagnosed with epilepsy? _____

Do you smoke cigarettes, cigars or a pipe? _____ If yes, how much per day? _____

If no, have you ever smoked? _____ If yes, when did you stop? _____

Do you consume alcohol? _____ If yes, how much per week? _____

Allergies: Please check the drugs listed below if allergic. Add others as known.

Penicillin	Demerol	_____
Sulfa	Aspirin	_____
Codeine	Morphine	_____

Patient Information Sheet

Have you ever had problems or diseases in the areas listed below? If yes, please explain.

	<u>No</u>	<u>Yes</u>	<u>If yes, brief explanation:</u>
Eyes	_____	_____	_____
Ears	_____	_____	_____
Mouth	_____	_____	_____
Throat	_____	_____	_____
Lungs	_____	_____	_____
Stomach/Bowels	_____	_____	_____
Neuralgic	_____	_____	_____
Kidney/Bladder	_____	_____	_____
Blood Disorder	_____	_____	_____
Liver	_____	_____	_____
Extremities	_____	_____	_____
Circulation	_____	_____	_____
Psychiatric	_____	_____	_____
Other areas or diseases not listed:	_____	_____	_____

Have you ever taken cortisone? Yes _____ No _____ If yes, when? _____

Are you currently on any medications? Yes _____ No _____ If yes, please list.

Family Members Health Status (If deceased, list age and cause if known)

	<u>Age</u>	<u>Good</u>	<u>Fair</u>	<u>Poor</u>	<u>Known illnesses</u>
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brothers	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
Sisters	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
Sons	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
Daughters	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

Patient or Guardian Signature: _____

I hereby attest that I have reviewed the information contained herein.

Arnaldo A. Garro, M.D.