THEODORE H. GAYLOR, M.D., F.A.C.S.

Name:	Cell Phone:	Home Phone:
Social Security No.:	Age: Birth Date: / /	Sex: ❑ M ❑ F
Address:	EMAIL:	
City: State: Zip:	Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Other	
Family Physician:	Physician Phone:	
Pharmacy Name:	Pharmacy Phone :	

Referred by: ❑ Yellow Book ❑ Verizon Book ❑ Friend ❑ Website/Internet ❑ Physician ____________________________

List problem/problems you are here for: ____

____

How long have you had this problem? ____

DO YOU:
- ❑ Snore?
- ❑ Stop breathing while sleeping?
- ❑ Feel tired or fall asleep during the day?

Past Medical History

Have you had any of these medical problems?

- ❑ Anemia
- ❑ Asthma
- ❑ Cancer
- ❑ Diabetes
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart attack
- ❑ High blood pressure
- ❑ Kidney problems
- ❑ Rheumatic fever
- ❑ Other ______________________________
- ______________________________

Do you have any bleeding disorders? ❑ Yes ❑ No

Are you taking any aspirin products/blood thinner? ❑ Yes ❑ No

Do you take antibiotics prior to surgical or dental procedures because of heart conditions? ❑ Yes ❑ No

Medications

If you are taking any medications, please list them.

NAME OF MEDICATION	DOSAGE	DAILY DIRECTIONS
Example	*1.5 mg*	*1 tablet 4x a day*
1.		
2.		
3.		
4.		
5.		
6.		

Surgical History

Check only those that apply:

- ❑ Adenoidectomy
- ❑ Appendectomy
- ❑ Artificial joints/limbs
- ❑ Brain surgery
- ❑ Cataract
- ❑ Carotid
- ❑ Ear surgery
- ❑ Gall bladder
- ❑ Heart
- ❑ Hernia
- ❑ Hysterectomy
- ❑ Lung
- ❑ Nasal surgery
- ❑ Prostate
- ❑ Sinus surgery
- ❑ Spleen surgery
- ❑ Tonsillectomy
- ❑ Vascular
- ❑ Other ____________________
- ____________________

Allergic History

Do you have any allergies (drugs, food, surgical tape, etc.)?

❑ Yes ❑ No Please specify ______________________________

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Children Only -

Are all vaccinations up-to-date? ❑ Yes ❑ No

Female Patients -

Number of children?___________

Are you pregnant? ❑ Yes ❑ No

Do you take oral contraceptives? ❑ Yes ❑ No

Family History

Check diseases in blood relatives only:

- ❑ Allergies
- ❑ Bleeding problems
- ❑ Cancer
- ❑ Diabetes
- ❑ Hearing loss
- ❑ Rheumatic fever
- ❑ High blood pressure
- ❑ Tuberculosis
- ❑ Other: ____

Social History

Do you smoke? ❑ Yes ❑ No Packs per day ______________ Occupation: ______________________________

Do you drink alcoholic beverages? ❑ Yes ❑ No If yes, drinks per week__________ ______________________________