Nasal Surgery Consultation Dean P Kane, MD, FACS, PA

Name: ________________________________ Age:________ Date:_______

Thank you for choosing our office for your consultation! Please check or fill in the following information so I may better help you.

My concerns include: (please circle):
breathing obstruction nasal appearance

These concerns have **bothered me for _______ years**.

List and date any prior nasal surgery or injury:

List / circle if the following apply:
- Y N medications, antibiotics, steroids, other medications or drugs in my nose:
- Y N use of recreational drugs now or in past in my nose: List if any:
- Y N acute or chronic sinusitis: List drugs and sprays used:
- Y N skin cancer, cysts, tumors on my nose:
- Y N acute or chronic rhinitis (drainage from nose). List drugs and sprays used:
- Y N eyeglasses
- Y N laser or chemical peel procedures (accutane, retinoids, glycolic acid, TCA, phenol, other:
- Y N radiation or PUVA skin treatment to nose or face