RUSSELL H. GRIFFITHS, M.D.
KRISTI L. WAYMENT, P.A.-C.
Craniofacial & Pediatric Plastic and Reconstructive Surgery
Ear Reconstruction Specialist

HEALTH HISTORY FORM (Please complete and fax to (208)433-1736)

Name _____

Date of Birth_____

Allergies_____

MEDICATIONS you are taking

MEDICAL HISTORY (Circle all that apply)

☐Microtia	☐right	☐Left	☐Bilateral
☐Aural Atresia	☐right	☐Left	☐Bilateral

☐Hemifacial microsomia ☐Pfeiffer Syndrome

☐Golderhar syndrome ☐Nager Syndrome

☐Treacher Collins Syndrome ☐18-q Deletion

☐Branchio-Oto-Renal Syndrome ☐CHARGE Syndrome

☐Other (Please explain)

Last hearing test result of the unaffected ear

Current hearing aid

SURGICAL HISTORY (Please list each surgery, when, where and name of surgeon)

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