

PATIENT HEALTH HISTORY

Accurate completion of this form enables our doctor to provide quality health care.

PATIENT NAME _____ DOB: _____ SEX: M ___ F ___

PRIMARY CARE PHYSICIAN: _____ PHARMACY NAME: _____ PHONE: _____

1. List **all medications** you are currently taking: _____

2. Do you have any **allergies to medications**? No ___ Yes ___ If yes to: _____

3. List any previous **surgeries** with dates: _____

4. Are you **pregnant**? No ___ Yes ___
 5. Do bleed excessively if cut? No ___ Yes ___
 6. Do you bruise easily? No ___ Yes ___
 7. Have you had any blood transfusions? No ___ Yes ___

8. CIRCLE IF YOU ARE BEING TREATED OR HAVE BEEN TREATED FOR ANY OF THE FOLLOWING AND WHEN

Anemia	Hemophilia	Kidney Stones	Stomach Ulcer / Bleed
Asthma: Mild or Severe	Hepatitis / Liver Disease	Rheumatic Fever	Thyroid: Low / High
Cancer of _____	High Blood Pressure	Stroke TIA	Tuberculosis
Diabetes	High Cholesterol	Psychiatric Problem _____	
Epilepsy / Seizures	HIV Positive	Respiratory Problem _____	
Heart Problem	Kidney Failure	Other _____	

9. Alcohol Use? No ___ Yes ___ *If yes, how many drinks per week?* _____
 10. Tobacco Use? No ___ Yes ___ *If yes, Packs per day* _____ *for* _____ *Years*
 Have you ever smoked? No ___ Yes ___ *If yes, Packs per day* _____ *What year did you quit smoking?* _____

11. FAMILY HISTORY: CIRCLE IF A BLOOD RELATIVE OF YOURS HAS BEEN OR IS AFFECTED BY:

Alcoholism	Cancer of _____	Diabetes	Heart Disease
High Blood Pressure	Mental Illness	Seizure / Epilepsy	Sickle Cell Disease or Trait

12. WHAT IS THE **MAIN REASON** FOR THIS VISIT? _____

13. ENT REVIEW OF SYSTEMS: TO BE COMPLETED BY PATIENT. PLEASE CIRCLE ALL THAT APPLY

NOSE: No Complaints	EARS: No Complaints	THROAT: No Complaints	NECK: No Complaints
TRAUMA HISTORY: <i>When?</i>	PAIN: <i>Mild Severe</i> <i>Steady On/Off</i>	PAIN: <i>Burning Bleeding</i>	PAIN: <i>Where?</i>
NASAL DRAINAGE: <i>Clear Thick Colored</i>	HEARING DIFFICULTY: <i>Progressive Sudden</i> <i>Left Right Bilateral</i>	DIFFICULTY SWALLOWING: <i>Liquids Solids</i>	<i>Since when?</i> LUMP: <i>Where?</i>
POST NASAL DRAINAGE: <i>Clear Thick Colored</i>	DRAINAGE: <i>Clear Pus Blood</i>	CHANGE IN VOICE:	<i>Since when?</i>
ALLERGIC SYMPTOMS: <i>Seasonal All year</i>	RINGING: <i>Steady Pulsating</i>	COUGH: <i>Dry Productive</i>	SWELLING: <i>Where?</i>
CONGESTION BLOCKAGE	VERTIGO: <i>Dizziness Imbalance</i>	HEARTBURN: <i>Frequent Belching</i>	<i>Since when?</i>
CHANGE OF SMELL			

The above information is accurate and complete to the best of my knowledge. I will not hold my physician or any member of his/her staff responsible for any errors or admissions that I may have made in the completion of this form.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY _____ DATE: _____

REVIEWED BY: _____ DATE: _____