

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. WHAT IS THE MAIN REASON FOR THIS VISIT? _____

2. List all medications you are currently taking: _____

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

4. List any previous surgeries with dates _____

5. Are you pregnant? No ___ Yes ___ Do bleed excessively if cut? No ___ Yes ___

6. Do you bruise easily? No ___ Yes ___ Have you had any blood transfusions? No ___ Yes ___

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

Table with 4 columns listing medical conditions: Anemia, Hemophilia, Kidney Stones, Stomach Ulcer / Bleed; Asthma, Hepatitis / Liver Disease, Rheumatic Fever, Thyroid; Cancer of, High Blood Pressure, Stroke TIA, Tuberculosis; Diabetes, High Cholesterol, Psychiatric Problem; Epilepsy / Seizures, HIV Positive, Respiratory Problem; Heart Problem, Kidney Failure, Other.

8. Alcohol Use? No ___ Yes ___ if yes, how many drinks per week? _____

9. 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? _____

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

Table with 4 columns listing family history conditions: Alcoholism, Cancer of, Diabetes, Heart Disease; High Blood Pressure, Mental Illness, Seizure / Epilepsy, Sickle Cell Disease or Trait.

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

Large grid table for ENT review of systems with columns for NOSE, EARS, THROAT, NECK and rows for TRAUMA HISTORY, NASAL DRAINAGE, POST NASAL DRAINAGE, ALLERGIC SYMPTOMS, CONGESTION, CHANGE OF SMELL, HEARING DIFFICULTY, DIFFICULTY SWALLOWING, DRAINAGE, CHANGE IN VOICE, RINGING, COUGH, HEARTBURN, PAIN, SWELLING.

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

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY _____ DATE: _____

REVIEWED BY: _____ DATE: _____