Patient Name: Account No. DOB:

Patient Medical History Form (p. 1): Please provide the following medical information to the best of your ability:

Date:	Age:	List any ALLERGIES TO MEDICATIONS:
What are your concerns for today's visit?:		

Past Medical History:

1) Please check the "Yes" or "No" box to indicate if you have any of the following illnesses; for "Yes" answers, please explain

	Yes	No			Yes	No	
Diabetes	☐	☐		**Hepatitis or HIV**	☐	☐	
Heart Disease/cholesterol probs	☐	☐		**Allergy problems/therapy**	☐	☐	
Hypertension (high blood press)	☐	☐		**Thyroid Problems**	☐	☐	
Respiratory/Lung Problems	☐	☐		**Radiation to head & neck**	☐	☐	
Stomach or Intestinal Problems	☐	☐		**Facial trauma**	☐	☐	
Kidney problems	☐	☐		**Anesthesia problems**	☐	☐	
Neurological Problems	☐	☐		**Other Medical Diagnosis**	☐	☐	

2) **Please list any operations (and dates) you have ever had *(including tonsils & adenoids)*:**

3) **Please list any current medications (and amounts, times per day);**
(include aspirin, antacids, vitamins, hormone replacement, birth control, herbal supplements, OTC nasal sprays/cold/sinus/allergy meds):

Social History:

	Yes	No	Please list details below:
Do you smoke? List how much	☐	☐	
If no, did you smoke previously?	☐	☐	
How often do you drink alcohol?			
What is your occupation?			

Family History:

Please check the "Yes" or "No" box to indicate whether any relatives have any of the following illnesses:
If yes, please indicate which relative(s) have the problem

	Yes	No	
Hearing problems	☐	☐	
Cancer	☐	☐	
Bleeding disorder	☐	☐	
Heart problems	☐	☐	

Reviewed by:

Date: ____/____/____

Patient Name: **Account No.** **DOB:**

Patient Medical History Form (p. 2): Please provide the following medical information to the best of your ability:

Review of Systems:

1) Please check the "Yes" or "No" box to indicate whether you presently have any of the following symptoms:

2) For any "yes" responses, please check the "current" box if this symptom relates to the reason for your visit today

		Yes	No	Current		Yes	No	Current
ALLERGY	sneezing	☐	☐	☐	post-nasal drip	☐	☐	☐
	environmental allergy	☐	☐	☐				
ENT	ear pain or itch	☐	☐	☐	ear drainage	☐	☐	☐
	hearing loss	☐	☐	☐	ear noises	☐	☐	☐
	dizziness	☐	☐	☐	lightheadedness	☐	☐	☐
	nasal congestion	☐	☐	☐	sinus pressure or pain	☐	☐	☐
	sense of smell problem	☐	☐	☐	prob. snoring, apnea	☐	☐	☐
	hoarseness	☐	☐	☐	throat pain	☐	☐	☐
	throat clearing	☐	☐	☐	throat dryness/itching	☐	☐	☐
	dental problems	☐	☐	☐	TMJ problems	☐	☐	☐
RESPIR.	cough	☐	☐	☐	coughing blood	☐	☐	☐
	wheezing	☐	☐	☐	shortness of breath	☐	☐	☐
EYES	eye pain	☐	☐	☐	watery or itchy eyes	☐	☐	☐
	double vision	☐	☐	☐	decreased visual fields	☐	☐	☐
GI	difficulty swallowing	☐	☐	☐	heartburn	☐	☐	☐
NEURO	headache	☐	☐	☐	weakness	☐	☐	☐
	passing out	☐	☐	☐	numbness, tingling	☐	☐	☐
GENERAL	chills	☐	☐	☐	weight loss or gain	☐	☐	☐
	fatigue	☐	☐	☐	daytime sleepiness	☐	☐	☐
	anesthesia problems	☐	☐	☐				
ENDO	feel warmer than others	☐	☐	☐	feel cooler than others	☐	☐	☐
HEME/LYM	swollen glands	☐	☐	☐	sweating at night	☐	☐	☐
	bleeding problems	☐	☐	☐	easy bruising	☐	☐	☐
CARDIAC	chest pain	☐	☐	☐	palpitations	☐	☐	☐
OB/Gyn	pregnant	☐	☐	☐	breast feeding	☐	☐	☐
MSK	joint aches	☐	☐	☐	muscle aches	☐	☐	☐
SKIN	rash	☐	☐	☐	hives	☐	☐	☐
	itching	☐	☐	☐	skin or hair changes	☐	☐	☐
PSYCH	depression	☐	☐	☐	anxiety or panic	☐	☐	☐

PLEASE STOP HERE

Reviewed by: