



In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for the doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcomed to a copy of the report if you wish.

ear • nose • throat

Patient ID Number (Office Use) _____ Appointment Date _____ Doctor _____

Full Name _____ Male Female Date of Birth _____

Pharmacy Reference (include location) _____

Name of Primary Care (Family) Physician _____ Referring Physician _____

Reason for Visit _____

(1) Are you taking ANY kind of medication now? (This includes prescription, over-the-counter, or herbal medications.)

No Yes If yes, please list below *include dosages.*

Medication Name and Dosage	Problem being Treated	Date of Prescription	Prescribing Doctor

(2) ARE YOU ALLERGIC TO ANY MEDICATIONS? No Yes If yes, please list below.

Name of Medication	Type of Reaction

(3) Are you allergic to anything in the environment such as pollens, dusts, food, latex, etc.? No Yes

If yes, please indicate what you are allergic to: _____

Have you ever had an allergy test? No Yes If yes, Skin Test Blood Test (RAST)

(4) Have you ever been *DIAGNOSED* with any major health problem? Including but not limited to:

Cancer (type) _____ <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when _____	Kidney and Gender Problems:
Ear:	Renal Failure <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when _____
Hearing Loss <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when _____	Prostate Enlargement <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when _____
Chronic Infections <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when _____	Are you Pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes
Nose and Sinus:	Mental and Emotional:
Nasal Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when _____	Depression <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when _____
Heart and Blood Vessels:	Anxiety <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when _____
High / Elevated Cholesterol <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when _____	Glands, Hormones, & Sugar Control:
High Blood Pressure <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when _____	Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when _____
Heart Disease <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when _____	Thyroid Deficiency <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when _____
Heart Attack <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when _____	Thyroid Excess <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when _____
Lungs and Respiratory:	Neurological Problems:
Tuberculosis <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when _____	Stroke <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when _____
Stomach and Digestive:	Blood and Lymph Node Problems:
Duodenal Ulcer <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when _____	Anemia <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when _____
Hepatitis <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when _____	Immune & Infectious Problems:
Stomach Ulcer <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when _____	HIV <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when _____
	Infectious Mononucleosis <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when _____

Have you ever been *DIAGNOSED* with any other major health problem not listed above? No Yes If yes, please list

diagnosis and year the diagnosis was made: _____

(5) SURGERIES AND HOSPITALIZATIONS

Have you ever had any problems with anesthesia (being numbed or put to sleep)? No Yes

If yes, please list what sort of problems: _____

Have you ever had surgery? No Yes If yes, list any surgeries and when they were done: _____