



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 \_\_\_\_\_

Full Name \_\_\_\_\_  Male  Female Date of Birth \_\_\_\_\_ Race \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone Number \_\_\_\_\_ Work Phone Number \_\_\_\_\_ Other Phone \_\_\_\_\_

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:**

<b>Cancer (type)</b> _____ <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when _____	<b>Kidney and Gender Problems:</b>
<b>Ear:</b>	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
<b>Nose and Sinus:</b>	<b>Mental and Emotional:</b>
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 _____
<b>Heart and Blood Vessels:</b>	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 _____	<b>Glands, Hormones, &amp; Sugar Control:</b>
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 _____
<b>Lungs and Respiratory:</b>	<b>Neurological Problems:</b>
Tuberculosis <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when _____	Stroke <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when _____
<b>Stomach and Digestive:</b>	<b>Blood and Lymph Node Problems:</b>
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 _____	<b>Immune &amp; Infectious Problems:</b>
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: \_\_\_\_\_