Revised 01/31/2014

ENT ASSOCIATES

Appointment Date: _____

PATIENT HEALTH HISTORY

PLEASE FILL OUT EVERY ITEM. 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. It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

FULL NAME: _____ DATE OF BIRTH: _____ Height: _____ Weight: _____

PREFFERED NAME: _____ EMAIL ADDRESS: _____

CELL PHONE: _____ PHARMACY (INCLUDE LOCATION): _____

PRIMARY CARE PHYSICIAN: _____ REFERRING PHYSICIAN: _____

REASON FOR TODAYS VISIT: _____

_____

DO YOU HAVE ANY OTHER MEDICAL CONDITIONS (ex: heart, high blood pressure, diabetes, etc.) ___NO ___YES (LIST BELOW)

_____

HAVE YOU EVER BEEN TREATED WITH CHEMO OR RADIATION THERAPY? ___NO ___YES – WHEN? _____

ARE YOU TAKING ANY MEDICATIONS NOW? ___NO ___YES PLEASE LIST BELOW AND INCLUDE DOSAGES:
(Please include prescriptions, over-the-counter medications, herbal or vitamin supplements, nasal sprays, and/or eye drops)

MEDICATION NAME	DOSAGE	HOW OFTEN?	MEDICATION NAME	DOSAGE	HOW OFTEN?

ARE YOU ALLERGIC TO ANY MEDICATIONS? ___NO ___YES PLEASE LIST BELOW AND INCLUDE REACTION:

MEDICATION NAME	REACTION	MEDICATION NAME	REACTION

HAVE YOU HAD ANY PROBLEMS WITH ANESTHESIA (BEING NUMBED OR PUT TO SLEEP?) ___NO ___YES (LIST BELOW)

TYPE OF ANESTHESIA	REACTION	TYPE OF ANESTHESIA	REACTION

DO YOU OR ANY OF YOUR FAMILY MEMBERS HAVE AND BLEEDING DISORDERS? ___NO ___YES (LIST BELOW)

BLEEDING DISORDER	WHO?	BLEEDING DISORDER	WHO?

HAVE YOU HAD ANY SURGERIES ___NO ___YES (PLEASE LIST ANY SURGERIES AND INCLUDE DATES)

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

HAVE YOU BEEN HOSPITALIZED FOR NON-SURGICAL REASONS? ___NO ___YES (PLEASE LIST BELOW AND INCLUDE DATES)

REASON HOSPITALIZED	DATE	REASON HOSPITALIZED	DATE

_____ _____

SIGNATURE OF PATIENT/ LEGAL GUARDIAN **DATE**