

Past Medical History

Date: _____

Patient Name: _____ DOB: _____ Age: _____

Primary Care Physician: _____ Referring Physician: _____

How did you hear about our office? _____

Reason for today's visit: _____

Pharmacy (Telephone # and Address): _____

Medication Allergies	Type of Reaction
Food Allergy	
Surgical tape	

Current Medications (or provide list of medicines)	Dose

Do you use **tobacco**? Y : N What type? _____ How much? _____ packs/day How many years? _____ If quit, when? _____

Do you drink **alcohol**? Y : N How much? _____

Could you be **pregnant** now? Y : N

Occupation: _____

Medical History - Have you ever suffered from these problems? (Please circle Yes or No)

Allergies / hayfever	Y : N	Ear infections	Y : N	Sinus infections	Y : N
Asthma	Y : N	Hearing loss	Y : N	Sleep apnea	Y : N
Bleeding problems	Y : N	Heart disease	Y : N	Stroke	Y : N
Cancer, if yes, Type	Y : N	High blood pressure	Y : N	Strep throat	Y : N
		HIV / AIDS	Y : N	Tonsillitis	Y : N
		Kidney disease	Y : N	TMJ / Jaw joint problems	Y : N
		Liver disease	Y : N	Thyroid disorder	Y : N
		Hepatitis C	Y : N	Tuberculosis	Y : N
		Pulmonary disease	Y : N	Other	
Diabetes	Y : N	Reflux	Y : N		

Previous Surgery

Adenoidectomy	Y : N	Angioplasty / stents	Y : N	Anesthesia problems	Y : N
Tonsillectomy	Y : N	Heart surgery	Y : N	If yes, type of reaction:	
Ear tubes	Y : N				
Ear surgery, other	Y : N	Appendectomy	Y : N	Other operations:	
Septoplasty	Y : N	Gallbladder	Y : N		
Sinus surgery	Y : N	Hernia repair	Y : N		
Thyroid surgery	Y : N	Hysterectomy	Y : N		

Family History – Have any of your blood related relatives ever suffered from these problems?

Allergies / hayfever	Y : N	Diabetes	Y : N	Sleep apnea	Y : N
Asthma	Y : N	Ear infections	Y : N	Snoring	Y : N
Bleeding problems	Y : N	Hearing loss	Y : N	Thyroid disorder	Y : N
Cancer, if yes, Type	Y : N	Heart disease	Y : N	Other:	
		Anesthesia reaction	Y : N		

