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	
Diabetes	☐	☐	
Hypertension (high blood pressu	☐	☐	
Thyroid Problems	☐	☐	
Heart Disease/cholesterol probs	☐	☐	
Respiratory Problems	☐	☐	
Stomach or Intestinal Problems	☐	☐	
Allergy problems/therapy	☐	☐	
Kidney 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 type of alcohol do you prefer?			
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	☐	☐	
Allergy	☐	☐	
Diabetes	☐	☐	
Cancer	☐	☐	
Bleeding disorder	☐	☐	
Anesthesia problems	☐	☐	
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	☐	☐	☐	problem snoring, apnea	☐	☐	☐
	hoarseness	☐	☐	☐	throat pain	☐	☐	☐
	throat clearing	☐	☐	☐	throat dryness/itching	☐	☐	☐
RESPIR.	cough	☐	☐	☐	coughing blood	☐	☐	☐
	wheezing	☐	☐	☐	shortness of breath	☐	☐	☐
EYES	eye pain	☐	☐	☐	watery or itchy eyes	☐	☐	☐
GI	difficulty swallowing	☐	☐	☐	heartburn	☐	☐	☐
NEURO	headache	☐	☐	☐	weakness	☐	☐	☐
	passing out	☐	☐	☐	numbness, tingling	☐	☐	☐
GENERAL	chills	☐	☐	☐	weight loss or gain	☐	☐	☐
	fatigue	☐	☐	☐	daytime sleepiness	☐	☐	☐
ENDO	feel warmer than others	☐	☐	☐	feel cooler than others	☐	☐	☐
HEME/LYM	swollen glands	☐	☐	☐	sweating at night	☐	☐	☐
	bleeding problems	☐	☐	☐	easy bruising	☐	☐	☐
CARDIAC	chest pain	☐	☐	☐	palpitations	☐	☐	☐
MSK	joint aches	☐	☐	☐	muscle aches	☐	☐	☐
GU	frequent urination	☐	☐	☐	painful urination	☐	☐	☐
SKIN	rash	☐	☐	☐	hives	☐	☐	☐
	itching	☐	☐	☐	skin or hair changes	☐	☐	☐

PLEASE STOP HERE

Reviewed by: