AFFILIATED EAR, NOSE & THROAT PHYSICIANS

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MEDICAL HISTORY

Patient Name: _____Date:_____

Age:_____Height:_____ Weight:_____

Reason for today's visit: _____

Please check any of the following conditions that you now have (or have ever had):

Y ❑ N ❑ Asthma
Y ❑ N ❑ Hay Fever
Y ❑ N ❑ Allergy Problems
Y ❑ N ❑ Hives
Y ❑ N ❑ Allergic reaction to Local Anesthesia
Y ❑ N ❑ Skin cancer
Y ❑ N ❑ Family history of skin Cancer
Y ❑ N ❑ Positive skin test for TB
Y ❑ N ❑ Stomach problems
Y ❑ N ❑ Anemia
Y ❑ N ❑ Artificial heart valve

Y ❑ N ❑ Abnormal Chest x-ray
Y ❑ N ❑ High blood pressure
Y ❑ N ❑ Chest Pain
Y ❑ N ❑ Heart Attack
Y ❑ N ❑ Heart Murmur
Y ❑ N ❑ Irregular heartbeat
Y ❑ N ❑ Joint pains/arthritis
Y ❑ N ❑ Thyroid problems
Y ❑ N ❑ Kidney disease
Y ❑ N ❑ Cold sores
Y ❑ N ❑ Pacemaker
Y ❑ N ❑ Mitral valve prolapse
Y ❑ N ❑ Exposure to AIDS

Y ❑ N ❑ Blood clots in lung
Y ❑ N ❑ Seizures
Y ❑ N ❑ Nervous Disorders
Y ❑ N ❑ Shingles
Y ❑ N ❑ Stroke
Y ❑ N ❑ Faint easily
Y ❑ N ❑ Glaucoma
Y ❑ N ❑ Cataracts
Y ❑ N ❑ Diabetes
Y ❑ N ❑ Liver disease
Y ❑ N ❑ Hepatitis
Y ❑ N ❑ Artificial joints

Y ❑ N ❑ I take aspirin

Y ❑ N ❑ I take a blood thinner

Y ❑ N ❑ I take antibiotics before surgical procedures

I take the following medications/herbal supplements: _____

I am **allergic** to the following medications: _____

I drink_____alcoholic beverages per week

I smoke_____cigarettes per day

I **am** ❑/**am not** ❑ pregnant

I **am** ❑/**am not** ❑ now nursing

I have had the following surgeries: _____

I have the following medical conditions not mentioned above: _____

_____

My personal physician is:_____

My pharmacy of choice is: _____

Completed by: ❑ Patient ❑ Nurse