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 ☐Parent ☐Nurse