AFFILIATED EAR, NOSE & THROAT PHYSICIANS

Roman J. Dykun, M.D., F.R.C.S. (C) • Christopher B. Standage, M.D.
S. Alex Kim, M.D. • Mobeen A. Shirazi, M.D.

MEDICAL HISTORY

Patient Name: _____Date:_____

Date of birth: _____Height:_____ Weight:_____

Reason for today's visit: _____

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

☐Asthma
☐Hay Fever
☐Allergy Problems
☐Hives
☐Allergic reaction to Local Anesthesia
☐Skin cancer
☐Family history of skin Cancer
☐Positive skin test for TB
☐Stomach problems
☐Anemia
☐Artificial heart valve
☐Abnormal Chest x-ray
☐High blood pressure
☐Chest Pain
☐Heart Attack
☐Heart Murmur
☐Irregular heartbeat
☐Joint pains/arthritis
☐Thyroid problems
☐Kidney disease
☐Cold sores
☐Pacemaker
☐Mitral valve prolapse
☐Exposure to AIDS
☐Blood clots in lung
☐Seizures
☐Nervous Disorders
☐Shingles
☐Stroke
☐Faint easily
☐Glaucoma
☐Cataracts
☐Diabetes
☐Liver disease
☐Hepatitis
☐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 have had the following surgeries: _____

I drink_____alcoholic beverages per week

I smoke_____cigarettes per day

I **am/am not** pregnant

I **am/am not** now nursing

I have the following medical conditions not mentioned above: _____

_____

My personal physician is: _____

My pharmacy of choice is: _____

Completed by: ☐Patient ☐Nurse