Account #__________________

PATIENT MEDICAL HISTORY

Patient Name______________________________________Date of Birth ____________Today's Date _________

Height ______ Weight ______ Pharmacy Name & Location: ____

Brief reason for today's visit:

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List any tests performed related to your condition (e.g. blood work, ultrasound, CT scan, or MRI):

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Personal Health History

- Heart Disease (heart attack, stents, etc) ❑
- Stroke ❑
- High Blood Pressure ❑
- Diabetes ❑
- Asthma/Emphysema/COPD ❑
- Hepatitis ❑
- HIV+ ❑
- Anesthesia problems ❑

List other medical problems (even if they are under control): ❑ None

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List all surgeries you have had & approximate dates (Please include non-Ear/Nose/Throat surgeries): ❑ None

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Family History

(Parents, children, siblings, grandparents)

- Thyroid cancer ❑
- Otitis media (ear infections) ❑
- Hearing loss ❑

Please list Allergies to medications: ❑ None

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Allergy to latex:	❑ Yes	❑ No
Allergy to tape:	❑ Yes	❑ No
Allergy to iodine/IV dye:	❑ Yes	❑ No

List all medications, herbs or other supplements you presently take, and their dosage: ❑ None

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Do you now, or have you ever used:

1. Tobacco? ❑ Current ❑ Former ❑ Never
   If yes, how many packs per day? _____________
   Year Started__________ Year Quit __________
2. Alcohol? ❑ Current ❑ Former ❑ Never
   If yes, how many drinks per week? ___________

Do you have a heart murmur? ❑ Y ❑ N

Do you take any blood thinners? ❑ Y ❑ N

Do you have a pacemaker? ❑ Y ❑ N

Have you had hip/knee/joint replacement? ❑ Y ❑ N

Do you need to take an antibiotic before routine dental work? ❑ Y ❑ N

Do you or any member of your family have malignant hyperthermia or other problem with anesthesia? ❑ Y ❑ N

Additional pertinent information:

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