



Please indicate all past and present medical history and the dates of any surgical procedures if known.

Patient Name _____ Age _____ Date of Birth _____

Temp: _____ Pulse: _____ O2% _____

ENT HISTORY

- | | |
|---|--|
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Anesthesia Problems |
| <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Meniere's Disease | |

MEDICAL HISTORY

- | | |
|--|--|
| <input type="checkbox"/> Heart Disease/ Heart Attack _____ | <input type="checkbox"/> Stroke/Vascular Disease _____ |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Cancer (indicate location) _____ | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> COPD/emphysema |
| <input type="checkbox"/> Kidney Disease/Problems | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Stomach Ulcer | <input type="checkbox"/> Spine Problems |
| <input type="checkbox"/> Other _____ | |
-

SURGICAL HISTORY

- | | |
|--|---|
| <input type="checkbox"/> Sinus Surgery (date) _____ | <input type="checkbox"/> Tonsil/Adenoid Surgery (date) _____ |
| <input type="checkbox"/> Ear Tubes (date) _____ | <input type="checkbox"/> Thyroid Surgery (date) _____ |
| <input type="checkbox"/> Parathyroid Surgery (date) _____ | <input type="checkbox"/> Eardrum Repair (tympanoplasty) _____ |
| <input type="checkbox"/> Mastoidectomy/Mastoid surgery _____ | <input type="checkbox"/> Cardiac Angioplasty (date) _____ |
| <input type="checkbox"/> Cardiac Bypass (date) _____ | <input type="checkbox"/> Heart Valve Replacement (date) _____ |
| <input type="checkbox"/> Carotid Endarterectomy (date) _____ | <input type="checkbox"/> Joint Replacement (date) _____ |
| <input type="checkbox"/> Stomach Surgery (date) _____ | |
| <input type="checkbox"/> Other _____ | |
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SOCIAL HISTORY

___ Tobacco Use (___ Packs/Day x ___ Years)

___ Alcohol Use (___ Drinks/Day)

___ Second Hand Smoke Exposure x ___ Years

___ Illicit Drug Use (Type _____)

___ Caffeine (___ Cups/Day)

Most Recent Primary Occupation _____

FAMILY HISTORY

(List relationship to patient)

___ Heart Disease/ Heart Attack _____

___ Stroke/Vascular Disease _____

___ High Blood Pressure _____

___ Diabetes _____

___ Cancer (indicate location) _____

___ Thyroid Disease _____

___ Asthma _____

___ COPD/emphysema _____

___ Kidney Disease/Problems _____

___ Seizure Disorder _____

___ Stomach Ulcer _____

___ Spine Problems _____

___ Other _____

MEDICATION LIST (TYPE, STRENGTH, DOSAGE)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES TO MEDICATIONS AND THEIR REACTIONS

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

LOCAL PHARMACY

ADDRESS

PHONE

MAIL ORDER PHARMACY

ADDRESS

PHONE
