ENT Specialists, Inc.

Health History Form

NAME: **DOB:** **Primary Care: Dr.**
HT: **WT:**
Reason for Visit:

_____

_____

_____

Please Circle Any Pertinent Medical History
Heart disease Acid Reflux Seasonal Allergies Sinus Disease High Blood Pressure Asthma Glaucoma Thyroid Disease Diabetes Arthritis Sleep Apnea Cancer _____ Emphysema/Bronchitis Bleeding Issues Reaction to Anesthesia

Past Surgical History: List any operations/hospitalization.
1. _____ 2. _____
3. _____

Medication (over the counter and prescription medications) **Flu Shot: YES or NO**

_____

_____

_____

Allergies to Medications (circle reactions that apply)

No Known Drug Allergies (NKDA)
Latex allergy: YES or NO
Medication: _____ Rash Hives Anaphylaxis GI upset Other_____ Medication: _____ Rash Hives Anaphylaxis GI upset Other_____ Medication: _____ Rash Hives Anaphylaxis GI upset Other_____
Occupation: _____

_____
Smoker: Yes or No Current Smoker: Packs/day_____ Years smoked_____
Prior Smoker: Quit_____ Packs/day_____ Years smoked_____ **Chewing Tobacco: Yes or No**
Alcohol: Drinks per day_____ or per week_____
Coffee: Cups/day _____
Patient Signature: _____
Date: _____
Physician Reviewer: _____

Date: _____