ENT Specialists Health History Form

NAME: «FirstName» «LastName»
DOB: «DOB»
Primary Care: Dr. «PcpFName» «PcpLName»

Reason for Visit: _____

_____

Height:_____ **Weight:**_____

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)

_____ _____ _____ _____

_____ _____ _____ _____

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: _____