

# EAR NOSE & THROAT MEDICAL CENTER

## Patient Information (Please Print)

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
First Middle Initial Last

## MEDICAL HISTORY:

Are you allergic to any medication?  Yes  No Please list: \_\_\_\_\_

Are you currently taking any medication?  Yes  No Please list: \_\_\_\_\_

## PAST SURGICAL HISTORY:

Have you had any surgical procedures?  Yes  No Please list: \_\_\_\_\_

Are you pregnant?  Yes  No How many months? \_\_\_\_\_ Breast-feeding?  Yes  No

Have you taken a cortisone drug recently?  Yes  No For what? \_\_\_\_\_

**SOCIAL HISTORY: DO YOU...**  Use Herbal Products? Please List: \_\_\_\_\_

<input type="checkbox"/> Exercise Regularly Type: _____ How Often: _____	<input type="checkbox"/> Use Alcohol Beer/Wine/Liquor How Often: _____	<input type="checkbox"/> Use Tobacco Cigarettes/Cigars/Pipe/Snuff/Chew Tobacco How Often: _____
--	--	---

## PATIENT MEDICAL HISTORY: Have you ever had or still have (Check for yes):

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Migraines	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Nervous Problems	<input type="checkbox"/> Cancer	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Anemia/Sickle Cell
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> T.B.	<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy/Convulsions
<input type="checkbox"/> Kidney or Bladder Disease	<input type="checkbox"/> Sinus/Allergy Problems	<input type="checkbox"/> Gout	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Circulation Problems/Stroke/Paralysis	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Stomach, Intestine, or Bowel Disorder	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Birth Defects	<input type="checkbox"/> Bleeding Problems
<input type="checkbox"/> AIDS or HIV related illness	<input type="checkbox"/> Liver Problems/Jaundice	<input type="checkbox"/> Skin Problems	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Other _____		

## FAMILY HISTORY: Have any blood relatives had (please indicate which relative):

<input type="checkbox"/> Heart Disease _____	<input type="checkbox"/> Thyroid Problems _____	<input type="checkbox"/> T.B. _____
<input type="checkbox"/> Glaucoma _____	<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Stroke _____
<input type="checkbox"/> Epilepsy _____	<input type="checkbox"/> High Blood Pressure _____	<input type="checkbox"/> Asthma _____
<input type="checkbox"/> Bleeding Problems _____	<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Other _____

**INSURANCE AUTHORIZATION AND ASSIGNMENT** (Please read and sign): I hereby authorize ENT Medical Center to furnish information to insurance carriers (and doctor's offices) concerning my illness and treatments. This signature also authorized you to give me reasonable and proper care by today's standards. I understand that I am responsible for all fees, regardless of my insurance coverage. In order to expedite insurance company payments, the necessary terms will be completed by this office. It is customary to pay for services when rendered unless other arrangements have been made in advance. I will also be responsible for any legal or other costs incurred in the collection of this account.

**NOTE: Your health information will be kept confidential. Any information that we collect about you this form will be kept confidential in our offices.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I plan to pay for today's visit by:  
 Cash  Check  
 Credit Card