ENT Medical Center

Patient Information

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 & include Dosage: _____

_____

Have you had a flu vaccine this year? ❑ Yes ❑ No If yes, please list date (if known): _____

If you are 65 or older have you had a pneumonia vaccine? ❑ Yes ❑ No If yes, when (if known): _____

Do you have an Advance Directive? ❑ Yes ❑ No

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? ❑ Yes ❑ No Please List: _____

Exercise Regularly? ❑ Yes ❑ No
Type: _____
How Often? _____

Use Alcohol? ❑ Yes ❑ No
Beer/Wine/Liquor
How Often? _____

Have you ever used Tobacco? ❑ Yes ❑ No
Cigarettes/Cigars/Pipe/Snuff/Chew Tobacco
How Often? _____
Date Stopped: _____

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

- ❑ AIDS
- ❑ Alcoholism
- ❑ Allergy Problems
- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Bell's Palsy
- ❑ Birth Defects
- ❑ Bladder Problems
- ❑ Bleeding Problems
- ❑ Cancer - Type _____ When _____
- ❑ Cholesterol Problems
- ❑ Circulation Problems
- ❑ Convulsions
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart Problems
- ❑ High Blood Pressure
- ❑ HIV
- ❑ Intestinal Problems
- ❑ Kidney Problems
- ❑ Liver Problems
- ❑ Lung Problems
- ❑ Meniere's Disease
- ❑ Migraines
- ❑ Mitral Valve Disorders
- ❑ Mononucleosis
- ❑ Nervousness
- ❑ Neurological Problems
- ❑ Obstructive Sleep Apnea
- ❑ Paralysis
- ❑ Prostate Problems
- ❑ Reflux Problems
- ❑ Seizures
- ❑ Sickle-Cell Disease
- ❑ Sinus Problems
- ❑ Sjogren's Syndrome
- ❑ Skin Problems
- ❑ Stomach Problems
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Venereal Disease
- ❑ Vertigo

IMMEDIATE FAMILY HISTORY: Have any blood relatives had:

	Father	Mother	Brother	Sister	Son	Daughter
☐ Asthma	☐	☐	☐	☐	☐	☐
☐ Bleeding Problems	☐	☐	☐	☐	☐	☐
☐ Cancer	☐	☐	☐	☐	☐	☐
☐ Diabetes	☐	☐	☐	☐	☐	☐
☐ Epilepsy	☐	☐	☐	☐	☐	☐
☐ Glaucoma	☐	☐	☐	☐	☐	☐

	Father	Mother	Brother	Sister	Son	Daughter
☐ Heart Disease	☐	☐	☐	☐	☐	☐
☐ High Blood Pressure	☐	☐	☐	☐	☐	☐
☐ Stroke	☐	☐	☐	☐	☐	☐
☐ Thyroid Problems	☐	☐	☐	☐	☐	☐
☐ Tuberculosis	☐	☐	☐	☐	☐	☐

Signature: _____ **Date:** _____