

Patient Medical History

In order for us to obtain medical history, it is important that you fill this form out as completely as possible. It is important for you E.N.T to know you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to ac copy of it you wish.

Patient's full legal name _____ Male Female DOB _____

Pharmacy Preference & Location _____ Pharamacy Phone # _____

Family Physician _____ Referring Physician _____

Reason for today's visit _____ Today Date _____

Do You Smoke? Yes If Yes, what is your average pack per day? _____

No; If No have you ever? _____ List the # of years you should smoked & average Pack per day ____/____

Do you use chewing tobacco? YES NO If yes number of years used&average amount of per day____/____

Please list all medications you are currently taking prescribed & over the counter medications, vitamins or supplements:

NAME OF MEDICATIONS	WHY YOU ARE TAKING IT	& DOSAGE(id known)

Please list any MEDICATION ALLERGIES BELOW Please list any NON-MDICATION ALLERGIES BELOW

Medication Allergy	Type of Reaction	Item(example:tape,latex,)	Type of Reaction to the item

Surgeries & Hospitalizations

Have you ever had a problem with anesthesia (being numbed or put to sleep)? ___if yes please explain_____

Please list any surgeries you have had and try the dates or the year if possible_____

Current or most recent occupation _____Days and shift worked_____