

EAR, NOSE & THROAT ASSOCIATES OF MOUNTAIN HOME

PATIENT'S PERSONAL MEDICAL HISTORY

PATIENT NAME: _____ AGE: _____

HEIGHT _____ WEIGHT _____

CHIEF COMPLAINT (Why are you here?) _____

DRUG ALLERGIES: _____

FOOD ALLERGIES: _____

ENVIRONMENTAL ALLERGIES: _____

LIST ALL PRESCRIPTIONS AND MEDICATIONS:

NAME	DOSAGE (mg)	TIMES PER DAY (daily, twice daily, every 4 hours, etc.)

LIST ANY OVER-THE-COUNTER MEDICATIONS AND/OR HERBALS:

NAME	DOSAGE (mg)	TIMES PER DAY (daily, twice daily, every 4 hours, etc.)

ONGOING MEDICAL CONDITIONS:

	YES	NO		YES	NO
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Type _____		
Other _____					

LIST ALL SURGERIES:

LIST ALL INJURIES OR ACCIDENTS:

FAMILY HISTORY:

	LIVING	DECEASED	AGE OR AGE AT DEATH	CAUSE OF DEATH
FATHER	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
MOTHER	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
BROTHER(S) # _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
SISTER(S) # _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

IS THERE A HISTORY OF ANY OF THE FOLLOWING IN BLOOD RELATIVES OF YOURS? (CIRCLE ALL THAT APPLY)

HEART DISEASE HIGH BLOOD PRESSURE DIABETES STROKE CANCER (TYPE: _____) HEARING LOSS
 ALLERGIES ASTHMA BLEEDING DISORDER ANESTHESIA REACTION OTHER _____

PERSONAL HISTORY:

HAVE YOU EVER SMOKED? YES NO No. of packs per day _____ No. of Years _____
 IF QUIT, WHEN? _____ DO YOU USE SMOKELESS TOBACCO? _____

DO YOU DRINK? NEVER OCCASIONAL REGULARLY DID YOU EVER DRINK HEAVILY? YES NO

DO YOU USE ILLEGAL DRUGS? YES NO

DO YOU HAVE A HISTORY OF: POSITIVE TEST FOR HIV / AIDS? YES NO POSITIVE TEST FOR HEPATITIS? YES NO