

Patient Health History Form

rev 09/08

Patient Name: _____ DOB: ____/____/____ Date of Visit: ____/____/____

Chief Complaint: _____

MEDICATIONS: (please list all current medications including vitamins and over the counter meds)

ALLERGIC TO: (please list all medications, anesthetics, materials or food)

CURRENT MEDICAL CONDITIONS: (please list all current medical conditions, i.e. diabetes, high blood pressure)

PAST MEDICAL HISTORY: (please list all prior medical conditions)

SURGERIES/HOSPITALIZATIONS:

1. _____
2. _____
3. _____
4. _____

SOCIAL HISTORY: (MUST circle Yes or No)

Do you smoke? Y N In the past? _____
Do you drink alcohol? Y N How much? _____
Do you work? Y N Occupation _____
Marital Status: S M D W

Do you currently suffer from any of the following symptoms or problems? (MUST circle Yes or No)

Hearing Loss	Yes/No	Sneezing	Yes/No	Arthritis	Yes/No
Noise/ringing in ears	Yes/No	Dizziness	Yes/No	Bruising	Yes/No
Nasal Congestion	Yes/No	Skin Rash	Yes/No	Sleep Disturbance	Yes/No
Nasal Drainage	Yes/No	Weight Loss/Gain	Yes/No	Diabetes	Yes/No
Sore Throat	Yes/No	Thyroid Disease	Yes/No	Cancer	Yes/No
Trouble Swallowing	Yes/No	Weakness	Yes/No	Seizures	Yes/No
Hoarseness	Yes/No	Numbness	Yes/No	Fatigue	Yes/No
Chest Pain/Angina	Yes/No	Shortness of Breath	Yes/No	Heartburn	Yes/No
Depression	Yes/No	High Blood Pressure	Yes/No	Snoring	Yes/No

Do you or anyone in your family have difficulty with anesthesia? Yes/No If Yes, who _____

Do you or anyone in your family have a history of bleeding easily? Yes/No If Yes, who _____

Patient (Guardian) Signature: _____ **Date:** ____/____/____

Physician's Signature: _____ **Date:** ____/____/____