ENT SURGICAL ASSOCIATES
MEDICAL HISTORY

TODAY'S DATE _____

First Name_____ Middle _____Last _____

Date of Birth _____ Age _____ Gender _____

REASON FOR VISIT _____

DRUG ALLERGIES_____

MEDICATIONS that you are presently taking _____

_____

_____

PAST SURGERIES _____

_____

PAST MEDICAL HISTORY: Please check any of the medical conditions that you have had:

____ High Blood Pressure	____ Anemia	____ Thyroid Disease	____ Asthma
____ Bleeding Disorder	____ COPD	____ Liver Disease	____ Heart Disease
____ Kidney Disease	____ Stroke	____ Stomach Ulcer	____ Cancer
____ Arthritis	____ Glaucoma	____ Diabetes	____ AIDS or HIV+
____ Tuberculosis	____ Seizure	____ Other _____	

SOCIAL HISTORY: Smoking YES NO If yes, Years: _____ Amount:_____
Alcohol None Occasional Moderate Excessive
Smokeless Tobacco YES NO
Street Drugs YES NO

ALLERGY HISTORY: Allergy Tested: YES NO If yes, when: _____

Pets owned: Dogs Cats Other: _____

FAMILY HISTORY: Please check any of the medical conditions below that a blood relative has had:

____ High Blood Pressure	____ Heart Disease	____ Thyroid Disease	____ Adopted
____ Asthma	____ Diabetes	____ Liver Disease	
____ Stroke	____ Seizure	____ Cancer	

REVIEW OF SYSTEMS: Please check any of the following that you have now or have had in the past year:

____ Weight Change	____ Dry Eyes	____ Chronic Cough	____ Chest Pain
____ Chronic Diarrhea	____ Depression	____ Change in Voice	____ Difficulty Swallowing
____ Rapid Heart Beat	____ Heartburn	____ Blood in Stools	____ Joint or Muscle Pain
____ Easy Bruising	____ Migraines	____ Shortness of Breath	____ Swollen Feet/Ankles
____ Ringing in Ears	____ New or Changing Moles		