MOUNTAIN HOME ENT & ALLERGY

PATIENT'S PERSONAL MEDICAL HISTORY

PATIENT NAME: _____ **DOB:** _____ **AGE:** _____

CHIEF COMPLAINT (Why are you here?) _____

HEIGHT: _____ **WEIGHT:** _____ **DRUG ALLERGIES:** _____

Primary care provider (PCP): _____ **Referring doctor:** _____

LIST ALL PRESCRIPTIONS AND MEDICATIONS: **PREFERRED PHARMACY:** _____

NAME	NAME

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

NAME	NAME

ONGOING MEDICAL CONDITIONS: (please check)

Heart Disease	☐ **Yes**	☐ **No**	**Type:** _____
High Blood Pressure	☐ **Yes**	☐ **No**	
Diabetes	☐ **Yes**	☐ **No**	**Type:** _____
Cancer	☐ **Yes**	☐ **No**	**Type:** _____
Stroke	☐ **Yes**	☐ **No**	
Thyroid Disease	☐ **Yes**	☐ **No**	**Type:** _____
Lung Disease	☐ **Yes**	☐ **No**	**Type:** _____

Other:_____

LIST ALL SURGERIES: _____

_____

LIST ALL INJURIES OR ACCIDENTS: _____

IS THERE A HISTORY OF ANY OF THE FOLLOWING (GRANDFATHER, GRANDMOTHER, FATHER, MOTHER OR SIBLINGS) (MARK ALL THAT APPLY AND STATE WHO)

	Who		Who
☐ **ANESTHESIA REACTION**	_____	☐ **HEARING LOSS**	_____
☐ **ASTHMA**	_____	☐ **HEART DISESASE**	_____
☐ **BLEEDING DISORDER**	_____	☐ **HIGH BLOOD PRESSURE**	_____
☐ **CANCER**	_____	☐ **STROKE**	_____
☐ **DIABETES**	_____	☐ **THYROID**	_____
☐ **OTHER**	_____	☐ **OTHER**	_____

PERSONAL HISTORY:

Have you ever smoked? ☐ **Yes** ☐ **No**
If, QUIT, when? _____

Number packs/day_____**Number of years**_____
Do you use smokeless tobacco? ☐ **Yes** ☐ **No**

Alcohol use ☐ **Yes** ☐ **No**
Do you use illegal drugs? ☐ **Yes** ☐ **No**
Positive test for HIV/AIDS ☐ **Yes** ☐ **No**

Did you ever drink heavily? ☐ **Yes** ☐ **No**

Positive test for Hepatitis? ☐ **Yes** ☐ **No**

Known food allergies: _____

Environmental allergies:_____