MOUNTAIN HOME ENT & ALLERGY

PATIENT'S PERSONAL MEDICAL HISTORY

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

CHIEF COMPLAINT (Why are you here?) _____

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

FAMILY DOCTOR: _____ **REFERRING DOCTOR:** _____

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

NAME	NAME

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

NAME	NAME

MEDICAL CONDITIONS: (please check)

- ☐ HIGH CHOLESTEROL
- ☐ HIGH BLOOD PRESSURE
- ☐ HEART ATTACK
- ☐ DIABETES
- ☐ THYROID DISEASE
- ☐ REFLUX/GERD
- ☐ BPH (LARGE PROSTATE)
- ☐ KIDNEY DISEASE
- ☐ ARTHRITIS
- ☐ OSTEOPOROSIS
- ☐ CVA/STROKE
- ☐ GLAUCOMA
- ☐ ANXIETY
- ☐ DEPRESSION
- ☐ ASTHMA
- ☐ COPD
- ☐ SLEEP APNEA
- ☐ FIBROMYALGIA
- ☐ HEART DISEASE
  Type _____
- ☐ CANCER
  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)

	Family Member		Family Member
☐ Anesthesia Reaction		☐ Hearing Loss	
☐ Asthma		☐ Heart Disease	
☐ Bleeding Disorder		☐ High Blood Pressure	
☐ Cancer		☐ Stroke	
☐ Diabetes		☐ Thyroid	
☐ OTHER			

PERSONAL HISTORY:

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

2nd hand smoke exposure? ☐ Yes ☐ No
Alcohol use ☐ Yes ☐ No
Drinks per day _____
Do you use illegal drugs? ☐ Yes ☐ No
Positive test for HIV/AIDS ☐ Yes ☐ No

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

Did you ever drink heavily? ☐ Yes ☐ No

Positive test for Hepatitis? ☐ Yes ☐ No

Patient Signature:_____ **Date:**_____

Responsible Party Signature:_____ **Date:**_____