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)

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

LIST ALL SURGERIES: ________________________

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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? ____________________

Number packs/day__________Number of years________
Do you use smokeless tobacco? ☐ Yes ☐ No

2nd hand smoke exposure? ☐ Yes ☐ No
Alcohol use ☐ Yes ☐ No
Drinks per day __________

Did you ever drink heavily? ☐ Yes ☐ No

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

Positive test for Hepatitis? ☐ Yes ☐ No

Patient Signature:________________________ Date:____________

Responsible Party Signature:________________________ Date:____________