Health History

Name _____ DOB _____

Reason for today's visit (in detail) _____

_____

Drug Allergies ☐ Yes ☐ No List _____

_____

PAST MEDICAL HISTORY:

- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back problems
- ☐ Bleeding disorders
- ☐ Blood Disease
- ☐ Blurred Vision
- ☐ Cancer **Type**:_____
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Coronary Artery disease
- ☐ Cortisone Treatments
- ☐ Cough, persistent or bloody
- ☐ Diabetes
- ☐ Difficulty Swallowing
- ☐ Dizziness
- ☐ Ear Discharge
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Headaches
- ☐ Hearing loss
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis Type _____
- ☐ Herpes
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hoarseness
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Therapy
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Ringing in Ears
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Feet or Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Disorders
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or Growth on Head or Neck
- ☐ Venereal Disease

List any other disease or conditions:_____

_____

Any family History of Cancer, Heart Problems, etc. ☐ Yes ☐ No If YES list: _____

_____

PREVIOUS SURGERIES: (Please list all surgeries & dates)

- ☐ Appendectomy
- ☐ Cancer surgery
- ☐ Carotid surgery
- ☐ Cervical spine surgery
- ☐ C-Section
- ☐ Ear drum repair
- ☐ Extremity Surgery
- ☐ Gall Bladder
- ☐ Heart bypass
- ☐ Heart stent
- ☐ Hernia repair
- ☐ Hysterectomy
- ☐ Joint replacement
- ☐ Knee L/R_____
- ☐ Mastoidectomy
- ☐ Pacemaker
- ☐ Removal of neck mass
- ☐ Septoplasty
- ☐ Shoulder R/L_____
- ☐ Sinus surgery
- ☐ Thyroidectomy
- ☐ Tonsillectomy & adenoidectomy
- ☐ Tubes in ears
- ☐ Tympanoplasty
- ☐ Wisdom teeth
- ☐ Other_____

_____

Do you drink alcohol? ☐ Yes ☐ No How often?_____ ☐ Beer ☐ Wine ☐ Liquor

Do you smoke? ☐ Yes ☐ No How much per day? _____ ☐ Cigarettes ☐ Pipe ☐ Cigar ☐ Other

Have you ever smoked? ☐ Yes ☐ No How long ago did you quit?_____years ago

Do you use smokeless tobacco? ☐ Yes ☐ No How much? _____ Quit ☐ Yes ☐ No How long ago? _____

Do you use or have you ever used illicit drugs? ☐ Yes ☐ No If YES, how much, how often, and what type? _____

_____

Are you pregnant? _____ Due date _____ Are you nursing?_____

Signature of Patient_____ Date _____