Patient Health History

In order for us to obtain a complete medical history, it is important for you to fill out this form as complete as possible. This is very important information to identify past/current health concerns. **Please fill out every item.** This information will be entered into your chart, and you are welcome to a copy of the report if needed.

Name: ______________________________ **DOB:** ________________________
Preferred Pharmacy: ____
Primary Care (Family) Physician: _____________________________________

Current Medications

Medication Name	Dosage	How Often Take

Medication Allergies

Medication Name	Reaction

If you have any other medical problems not listed above, list those below.

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Surgeries and Hospitalizations
(that involve your ears, nose and/or throat)

Surgery	Date

Have you ever had any problems with anesthesia (being numbed or put to sleep)? Yes No
If yes, please list complications: ____