ENT and Allergy Associates of Florida

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MEDICAL HISTORY FORM

Patient Name: _____ **Date of Birth:** _____ **Gender:** Male

Referring Physician: _____ **Height:** _____ feet _____ inches **Weight:** ____ lbs

Primary Care Physician: _____

Pharmacy Name: _____ **Pharmacy Phone Number:** _____

Briefly, why are you seeing our physician today? _____

1. Patient History - Please check your response

	Yes	No		Yes	No
Cancer (enter details below)	[ ]	[ ]	Nasal: Allergies	[ ]	[ ]
Heart Disease (enter details below)	[ ]	[ ]	Nasal: Nasal Trauma	[ ]	[ ]
Cardio: Hypertension	[ ]	[ ]	Nasal: Nose Bleeds	[ ]	[ ]
Ear: Dizziness	[ ]	[ ]	Nasal: Sinusitis	[ ]	[ ]
Ear: Hearing loss	[ ]	[ ]	Neuro: Headaches/Migraines	[ ]	[ ]
Ear: Tinnitus/Ringing in ear	[ ]	[ ]	Neuro: Nervous System Disorder	[ ]	[ ]
Endocrine: Diabetes	[ ]	[ ]	Neuro: Seizure Disorder	[ ]	[ ]
Endocrine: Thyroid Disorder	[ ]	[ ]	Ophth: Eyes/Glaucoma	[ ]	[ ]
GI: Bowel Disorder	[ ]	[ ]	Oral: Sleep Apnea	[ ]	[ ]
GI: Liver Disorder	[ ]	[ ]	Psych: Psychiatric Disorder	[ ]	[ ]
GI: Stomach Disorder/Ulcers	[ ]	[ ]	Pulm: Lung Disease	[ ]	[ ]
GI: Reflux/Heartburn/GERD	[ ]	[ ]	Pulm: Tuberculosis	[ ]	[ ]
Immuno: HIV	[ ]	[ ]	Uro: Bladder Disorder	[ ]	[ ]
Immuno: Anemia	[ ]	[ ]	Uro: Kidney Disease	[ ]	[ ]
Immuno: Bleeding Disorder	[ ]	[ ]	Other (enter details below)	[ ]	[ ]

Details of 'Yes' answers: _____

_____

2. Surgeries - Please list any surgeries/hospitalizations: _____

_____

3. Social History

Are you a current smoker? No — You now smoke _____ packs of cigarettes a day.

Are you a former smoker? No — You smoked _____ packs/day & quit _____ years ago.

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you drink per day? _____

4. Family History - Please check your response

	Yes	No		Yes	No
Allergies	[ ]	[ ]	Premature Hearing Loss	[ ]	[ ]
Cancer	[ ]	[ ]	Sinusitis	[ ]	[ ]
Diabetes	[ ]	[ ]	Sleep Apnea	[ ]	[ ]
Headaches/Migraines	[ ]	[ ]	Thyroid Disorder	[ ]	[ ]
Immune Disease	[ ]	[ ]			

Details of 'Yes' answers: _____

_____

Patient Signature: _____ **Date:** _____