Ear Nose & Throat
OF SPRINGFIELD

Quality care, close to home.

Date:

Patient Name:

Age:

Date of Birth:

Patient Medical History (past and current)

- ☐ Allergies
- ☐ Hearing loss
- ☐ Cancer (type):
- ☐ Anemia (type):
- ☐ Arthritis (type):
- ☐ Asthma
- ☐ Anxiety and/or Depression
- ☐ Bleeding disorder (type):
- ☐ Diabetes (type):
- ☐ Emphysema
- ☐ COPD
- ☐ GE Reflux, heartburn
- ☐ Glaucoma
- ☐ High Blood Pressure
- ☐ Heart condition (type):
- ☐ Congestive Heart Failure
- ☐ Heart Attack / MI
- ☐ Pacemaker, Defib
- ☐ Kidney problem (type):
- ☐ Neurological problem (type):
- ☐ Other lung problem (type):
- ☐ Liver problem (type):
- ☐ Thyroid problem (type):
- ☐ HIV, Infectious disease
- ☐ Tuberculosis/TB
- ☐ Stroke/CVA
- ☐ Seizure disorder
- ☐ Other:

Family Medical History

	Who?	Maternal	Paternal
☐ Bleeding disorder		○	○
☐ Cancer		○	○
☐ Asthma		○	○
☐ Diabetes		○	○
☐ Heart Disease		○	○
☐ Stroke		○	○
☐ Anesthesia problem		○	○
☐ Hearing loss		○	○
☐ Other:		○	○

List Drug Allergies

Social History

Tobacco use: Yes, currently ○ No, never ○ I have in the past ○

What kind?

How much?

How long?

If you quit, when?

Do you drink alcohol?

Do you (currently or in the past) use recreational drugs?

How much caffeine do you drink a day?

Occupation:

Hobbies:

Medications

List all medications you are taking, including over the counter and herbal

Name	Dose

Surgical History

Anesthesia Problems?

If yes, explain.

Height

Weight

Print