ENT and Allergy Associates of Florida

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MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth: _____ M or F

Referring Physician: _____ *Pharmacy Name _____

*Pharmacy Cross Street _____

*Pharmacy Phone Number _____

Primary Care Physician: _____ **Weight:** _____ **Height**: _____

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 (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	( )	( )
Endocrine: Diabetes	( )	( )	Neuro: Seizure Disorder	( )	( )
Endocrine: Thyroid Disorders	( )	( )	Ophth: Eyes/Glaucoma	( )	( )
G.I.: Bowel Disorders	( )	( )	Oral: Sleep Apnea	( )	( )
G.I.: Liver Disorders	( )	( )	Pysch:PsychiatricDisorders	( )	( )
G.I.: Stomach Disorders/Ulcers	( )	( )	Pulm: Lungs	( )	( )
G.I.: Reflux/GERD/Heartburn	( )	( )	Pulm: Tuberculosis	( )	( )
Immuno: HIV	( )	( )	Uro:Bladder Disorders	( )	( )
Immuno: Immune Dieases	( )	( )	Uro: Kidney	( )	( )
Lymph: Anemia	( )	( )			
Lymph: Bleeding Disorders	( )	( )	Other: _____		

Details of Yes answers: _____

_____

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

_____

3. Social History - Are you a current smoker? (Y or N) You now smoke _____packs of cigarettes a day.

You smoked_____packs per day and quit_____years ago.

You consume_____alcoholic beverages per day / week / month (circle).

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/Migraine	( )	( )	Thyroid Disorders	( )	( )
Immune Disease	( )	( )			

Details of Yes answers: _____

Patient Signature: _____ Date: _____