North Valley Ear, Nose & Throat

PATIENT HISTORY

Date_____

Female ❑

Male ❑

Patient Name_____ Age_____ Date of Birth_____

Referred to this office by:_____ Primary Care Physician _____

Specialists treating you: _____

What medical problems bring you to this office? _____

_____

_____

_____

List all active or past medical problems treated by a doctor, including surgeries: _____

_____

_____

What PRESCRIPTION medications do you take and why?

MEDICATION	BEING TAKEN FOR	MEDICATION	BEING TAKEN FOR

What other non-prescription (over the counter, herbal or homeopathic) medications do you take? _____

_____

Do you have any allergies to medications? ( ) No ( ) YES (please list the names and type of reaction)

ALLGERIC TO	REACTION	ALLGERIC TO	REACTION

SOCIAL HISTORY:

Occupation _____

Do you smoke? ( ) NO ( ) YES How much? _____ packs per day. How long?_____ yrs.

Have you ever smoked? ( ) NO ( ) YES When did you quit?_____

Do you drink: Caffeinated beverages? ( ) NO ( ) YES Alcohol? ( ) NO ( ) YES How much? _____

Do you live: ( ) Alone ( ) With Spouse ( ) With Family ( ) With Friends ( ) Assisted Facility

FAMILY HISTORY:

	Age	Diseases/Conditions	If Deceased, Cause of Death
FATHER	_____	_____	_____
MOTHER	_____	_____	_____
SIBLINGS	_____	_____	_____
SPOUSE	_____	_____	_____
CHILDREN	_____	_____	_____

List any recent x-rays, labs or tests related to your visit: (type, date, facility, doctor)

_____

_____