ENT and Allergy Associates of Florida
CARING FOR OUR PATIENTS SINCE 1963

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
Cancer (enter details below)	( )	( )
Heart (enter details below)	( )	( )
Cardio: Hypertension	( )	( )
Ear: Dizziness	( )	( )
Ear: Hearing Loss	( )	( )
Ear: Tinnitus/Ringing in Ear	( )	( )
Endocrine: Diabetes	( )	( )
Endocrine: Thyroid Disorders	( )	( )
G.I.: Bowel Disorders	( )	( )
G.I.: Liver Disorders	( )	( )
G.I.: Stomach Disorders/Ulcers	( )	( )
G.I.: Reflux/GERD/Heartburn	( )	( )
Immuno: HIV	( )	( )
Immuno: Immune Dieases	( )	( )
Lymph: Anemia	( )	( )
Lymph: Bleeding Disorders	( )	( )

	Yes	No
Nasal: Allergies	( )	( )
Nasal: Nasal Trauma	( )	( )
Nasal: Nose Bleeds	( )	( )
Nasal: Sinusitis	( )	( )
Neuro: Headaches/Migraines	( )	( )
Neuro: Nervous System	( )	( )
Neuro: Seizure Disorder	( )	( )
Ophth: Eyes/Glaucoma	( )	( )
Oral: Sleep Apnea	( )	( )
Pysch:PsychiatricDisorders	Á)	( )
Pulm: Lungs	( )	( )
Pulm: Tuberculosis	( )	( )
Uro:Bladder Disorders	( )	( )
Uro: Kidney	( )	( )

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
Allergies	( )	( )
Cancer	( )	( )
Diabetes	( )	( )
Headaches/Migraine	( )	( )
Immune Disease	( )	( )

	Yes	No
Premature Hearing Loss	( )	( )
Sinusitis	( )	( )
Sleep Apnea	( )	( )
Thyroid Disorders	( )	( )

Details of Yes answers:____

Patient Signature:____ Date: ______________________