

**Please answer this questionnaire to the best of your knowledge. The information is confidential and will be used by the physicians of South dale Otolaryngology to evaluate and treat your medical problems.**

## SOUTH DALE OTOLARYNGOLOGY P.A. Patient Medical History Form

Today's Date \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

Name of your regular physician: \_\_\_\_\_

Preferred pharmacy and location: \_\_\_\_\_

1. ILLNESS or CONDITIONS - Are you under the care of a doctor for a specific illness or condition or have you been treated in the past for :

	YES	NO		YES	NO		YES	NO
Heart .....	0	0	Nervous system.....	0	0	Lung.....	0	0
Stomach or Bowels.....	0	0	Bone and Joint.....	0	0	Other.....	0	0
Kidney/Bladder.....	0	0	Chemical dependency	0	0	Hearing loss..	0	0
Diabetes.....	0	0	Cancer.....	0	0	Do you wear hearing aids? 0	0	0

2. MEDICAL PROBLEMS: \_\_\_\_\_

HOSPITALIZATIONS / SURGERIES: \_\_\_\_\_

3. BLOOD CONDITIONS

Have you had hepatitis? No \_\_\_ Yes \_\_\_ Date \_\_\_\_\_ Have you been tested for HIV? No \_\_\_ Yes \_\_\_ Results (optional) \_\_\_\_\_  
 Have you had any blood transfusions? No \_\_\_ Yes \_\_\_ Date \_\_\_\_\_  
 Any blood clotting or bruising problems? No \_\_\_ Yes \_\_\_

4. MEDICATIONS:

Are you Currently taking any prescription medications? No \_\_\_ Yes \_\_\_ Please list: \_\_\_\_\_

Are you Currently taking any over-the-counter medications? No \_\_\_ Yes \_\_\_ Please list: \_\_\_\_\_

5. ALLERGIES

Are you ALLERGIC to any medications? No \_\_\_ Yes \_\_\_ Please list: \_\_\_\_\_

Do you have any environmental allergies / hay fever? No \_\_\_ Yes \_\_\_

Have you been tested for allergies? No \_\_\_ Yes \_\_\_

6. Do you Smoke?

No \_\_\_ Yes \_\_\_ How many packs per day for how many years? \_\_\_\_\_ If you quit, when? \_\_\_\_\_

7. Do you drink alcoholic beverages? No \_\_\_ Yes \_\_\_ How many per week? \_\_\_\_\_ Or month? \_\_\_\_\_

Do You HAVE:	No	Yes		No	Yes		No	Yes
Recent weight loss? .....	0	0	Neck tenderness?.....	0	0	Voice changes?.....	0	0
Sweats / Chills? .....	0	0	Neck swelling? .....	0	0	Snoring? .....	0	0
Fever? .....	0	0	Reflux / Heartburn?..	0	0	Nasal drainage? .....	0	0
Headache? .....	0	0	Swallowing difficulty?	0	0	Nasal obstruction?..	0	0

8. FAMILY HISTORY No \_\_\_ Yes \_\_\_ Died of: \_\_\_\_\_

Mother living?      0      0      \_\_\_\_\_  
 Father living?      0      0      \_\_\_\_\_

Details:

Family history of hearing problems? No \_\_\_ Yes \_\_\_ \_\_\_\_\_

Family history of allergies? No \_\_\_ Yes \_\_\_ \_\_\_\_\_

**Physician use only      Date / Initials**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_