

GENERAL HISTORY

Who referred you to our practice? _____

What problem are you here for today? _____

What other ear, nose or throat problems do you have? _____

What previous surgery have you had on your head or neck? _____

What medicines are you taking currently? _____

Do you have allergies to medications? _____ If yes, which medications _____

What environmental allergies do you have? _____

Does anyone in your family have allergies? _____

What medical problems do you have? _____

What surgeries were done on you in the past? _____

Do you have any HIV risk factors? _____

Do you have glaucoma? YES NO Are you using any eye drop medication? _____

Did you ever smoke? _____ How many packs per day? _____ How many years? _____

Have you quit? _____ How long ago? _____

How much alcohol do you drink? _____

Were you ever a heavy user of alcohol? _____ When did you quit? _____

What significant medical problems do YOU or any of your family members have (i.e. cancer, high blood pressure, seizures, etc.)? _____

Patient/Guarantor Signature: _____ Date: _____

Physician: _____ Date: _____