

New Patient Health History Form



Last Name _____ First Name _____ M.I. _____

Date of Birth: __/__/____ Marital Status: _____ Sex: M F

Home Phone: (____) _____ Alt Phone: (____) _____

If you would like us to send your ongoing medical records to another physician, please list them:

Family Doctor: _____ Referring Doctor: _____ Other Doctor: _____

Have you been seen by any of the physicians at Capital Otolaryngology? Yes No

Has a member of your family been seen by any of the physicians at Capital Otolaryngology? Yes (specify) _____ No

How did you hear about us? (please circle): Doctor Referral Internet Yellow Pages Insurance Friend Other _____

Reason for today's visit (please specify how long you have had these symptoms) _____

Have you had any tests, scans (CT or MRI), or treatments for this problem: Yes No

If yes, what was done and which doctor ordered them: _____

Answer all questions

1. MEDICAL HISTORY

Height _____ Weight _____

DO YOU HAVE OR HAVE YOU EVER HAD (please box)

- Heart Disease
- Hypertension
- High Cholesterol
- Asthma
- Lung Disease (specify _____)
- Seizures, Epilepsy, Fainting or Dizziness
- Bleeding Disorder, Anemia, Blood Transfusion or do you bruise easily
- Liver Disease (Jaundice, Hepatitis)
- Kidney Disease
- Diabetes
- Thyroid Disease (_____)
- Stomach Ulcers or Colitis
- Any disease, drug, or transplant operation that has depressed your immune system
- History of Cancer: Type _____
Treatment? _____ When diagnosed? _____
- Sleep/snoring problems
Please explain: _____
- Hearing problems
- Facial cosmetic concerns
Concern area: _____
- Do you have any other disease, condition or problem that you think the doctor should know about? _____

- No known medical conditions

All responses are kept confidential

2. MEDICATIONS

- Do you take any aspirins, Ibuprofen, Advil, Motrin, Vitamin E, or blood thinners?
- Please list all medications you take (include prescription & over-the-counter medications): _____

3. SURGICAL HISTORY

Please list any surgeries/hospitalizations you have had (please include date)? _____

4. ALLERGIES (write 'none' if you have no known allergies)

- a. Please list any **drug allergies** _____

- b. Please list any seasonal allergies or food allergies: _____

5. SOCIAL HISTORY:

- Do you smoke or chew Tobacco? How much per day? _____
- Do you drink Alcohol? How much per day? _____
- Do you have a Chemical Dependency or Emotional Disorder that may affect the care we provide you?

6. FOR WOMEN ONLY

- Are you pregnant, or is there any chance you might be pregnant?
- Are you nursing?

X

Patient/Guardian Signature

Print name

Date