Ear, Nose, Throat and Plastic Surgery Associates, P.C.

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. ***Please fill out every item.***

Full Name ______________________________________ **Birthdate** ____________________

CURRENT MEDICATIONS:
Are you taking ANY kind of medication now? (This includes prescription, over-the-counter or herbal medications)
☐ **No** ☐ **Yes** **If yes, please list below** ***include dosages***.

Medication Name	Dosage	When taken

MEDICATION ALLERGIES: ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ **No** ☐ **Yes**
If yes, please list below.

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATIONS:
Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ **No** ☐ **Yes**

If **yes**, please list what sort problems ____

Have you ever had ear, nose or throat surgery? ☐ **No** ☐ **Yes**

If **yes**, list any surgeries and when they were done.____

Have you ever had Heart Surgery ? ☐ **No** ☐ **Yes**

If **yes**, list any surgeries and when they were done.____

In the past, have you been hospitalized for a medical problem or a surgery? ☐ **No** ☐ **Yes**

If **yes**, list the reason for admission and the date. ______________________________________