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COMPREHENSIVE MEDICAL HISTORY

Please complete the following patient medical history information so that we may offer you/your child the proper medical care. Please mark where applicable for you or your child.

Patient Name:_____ Date of Birth:_____

PATIENT HISTORY: *(Please check any medical condition the patient has)*

- □ Seasonal Allergies
- □ Asthma
- □ ADD/ADHD
- □ Diabetes
- □ Arthritis Rheumatoid
- □ Bleeding Disorder
- □ TB
- □ Emphysema
- □ Hearing Loss
- □ COPD
- □ Recurrent Ear Infections
- □ High B/P
- □ Cancer
- □ HIV/AIDS
- □ Gastro paresis
- □ Speech Delay
- □ Seizures
- □ Behavioral Problems
- □ Stroke
- □ Dementia
- □ Sickle Cell Anemia
- □ Sickle Cell Trait
- □ Acid Reflux
- □ Sleep Apnea
- □ Parkinson's disease
- □ Problems w/Anesthesia
- □ Recurrent Tonsil Infections
- □ Stuffy Nose
- □ Obesity
- □ Dizziness/Vertigo
- □ ringing in the ears (Tinnitus)
- □ Heart Attack
- □ Blood Clots
- □ Coronary Artery Disease
- □ Thyroid Disease
- □ Liver Disease
- □ Hepatitis
- □ Pulmonary Embolism
- □ RSV
- □ Meningitis
- □ Depression
- □ Anxiety
- □ Diabetic Neuropathy
- □ Migraine Headaches
- □ Sinusitis
- □ Deep Vein Thrombosis (DVT)
- □ Congested Heart Failure (CHF)
- □ Fractures (type) _____
- other_____

SURGICAL HISTORY: *(Please check all that apply or fill in the blanks)*

- □ Sinus Surgery
- □ Nasal Surgery
- □ Tonsillectomy
- □ Salivary Gland Removal
- □ Eye Surgery
- □ Ear Tubes/Ear Surgery
- □ Neck Surgery
- □ Adenoidectomy
- □ Carotid Artery Surgery
- □ Appendectomy
- □ Thyroid Surgery
- □ Heart Surgery
- □ Septoplasty
- □ Brain Surgery
- □ Gall Bladder
- □ Cancer Surgery (type)_____
- □ Other Surgeries (please list)_____

KNOWN DRUG ALLERGIES Y N	FOOD ALLERGIES? Y N
Drug name:_____	Reaction:_____
Drug name:_____	Reaction:_____
Drug name:_____	Reaction:_____
Drug name:_____	Reaction:_____

ALL CURRENT MEDICATIONS: *(Include over the counter medications)*

_____

_____

PLEASE CONTINUE ON BACK SIDE

FAMILY MEDICAL HISTORY: *(If any of your parents, your child's parents, siblings, or grandparents have the followings diseases, please check and explain which relative)*

□ Diabetes □ Heart Disease □ High BP □ Cancer *(type)*_____
□ Bleeding Disorders □ Emphysema/TB □ Sickle Cell □ Seizures
□ Hearing Loss □ Thyroid Problems □ Developmental Problems _____
□ Other_____

SOCIAL HISTORY:

Does the patient participate in/is patient exposed to: *(Please circle one)*

□ Smoking Exposure Y N Participates Y N How many?_____
□ Alcohol Exposure Y N Participates Y N □ Daily □ Wknd □ Rarely
□ Drugs Exposure Y N Participates Y N Type?_____
□ Pet Exposure Y N Type?_____
□ Abuse Y N Type?_____

Does Patient attend School/Day Care? Y N

Name of School/Day Care: _____

Grade Level? _____

Do you exercise? Y N Type: _____ Frequency: _____

Developmental History: *(for children only)* **Please Circle**
Pregnancy & Birth Birth Weight: _____

During pregnancy:

Was mother treated for infection?	Y N
Was child treated for infection?	Y N
Low birth weight?	Y N
Problems at birth?	Y N
Premature?	Y N

If you answered yes to any of the questions about in this section, please explain?_____

_____

_____

REVIEW OF SYSTEMS *(Please check all that apply)*

□ Fever □ Itchy/Watery Eyes □ Heartburn
□ Anorexia □ Nasal Obstruction □ Hoarseness
□ Heart Trouble □ Abdominal Pain □ Hearing Loss
□ Palpitations □ Easy Bruising □ Post Nasal Drip
□ Chest Pain □ Weight Loss □ Runny Nose
□ High B/P □ Headache □ Rash/Eczema
□ Frequent Throat Clearing □ Blurred Vision □ Sleep Apnea
□ Difficulty Swallowing □ Dizziness □ Snoring
□ Ringing in Ears □ Stroke
□ Sneezing □ Cough

I acknowledge the above medical history to be true to the best of my ability.

Signature:_____ **Date:**_____