HEALTH HISTORY

Name:____ DOB: ____________________

Primary Care Provider: __________________________ Phone: ______________________

Referring Provider: _____________________________ Phone: ______________________
(If same as PCP, leave blank)

Local Pharmacy (include city or phone number): ______________________________________

Mail Order Pharmacy (if applicable): ____

CURRENT AND PAST MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

Lung Disorder- Type: ___________________________ Specialist: ____________________

Liver Disorder- Type: __________________________ Specialist: ____________________

Kidney Disorder- Type: _________________________ Specialist: ____________________

Heart Disorder- Type: __________________________ Specialist: ____________________

Infectious Disorder- Type: ______________________ Specialist: ____________________

Neurological Disorder- Type: ____________________ Specialist: ____________________

Gastrointestinal Disorder- Type: _________________ Specialist: ____________________

Autoimmune Disorder- Type: _____________________ Specialist: ____________________

Blood Disorder- Type: __________________________ Specialist: ____________________

Anxiety/ Depression Diabetes, Specialist: ____________________

High Blood Pressure Glaucoma, Specialist: ____________________

Stroke/ TIA (mini-stroke) Other: ______________________________

Cancer, Type: ____________________________ Specialist: __________________________

Do you have a Medical Advanced Directive? YES NO

If you do not, please list someone that you would like to appoint? ____________________________

DRUG AND FOOD ALLERGIES

(If you carry an EpiPen for any of these allergies, please circle it)

Allergy: ______________________________ Reaction: ________________________________

Allergy: ______________________________ Reaction: ________________________________

Allergy: ______________________________ Reaction: ________________________________

Allergy: ______________________________ Reaction: ________________________________

ENT & FACIAL PLASTIC SURGERY

SOCIAL HISTORY

Alcohol Consumption: YES, # of Drinks per week: ________ H/O alcohol abuse? ________ NO

Tobacco Consumption: YES, **(Circle)** Current/ Occasional/ Former, Type: __________ # Daily: _______

NEVER SMOKER

Caffeine Consumption: YES, Type: ________________________ # Daily: ___________ NONE

Exercise: YES, Type: _________________________ NO

Drug Use: NO YES, please describe: ___________________ History of drug abuse? ____________

Occupation: ____ **Student:** YES NO

PAST SURGICAL HISTORY

Procedure: ____ Date: ______________________

Procedure: ____ Date: ______________________

Procedure: ____ Date: ______________________

Procedure: ____ Date: ______________________

Please continue listing surgeries on the back side if applicable.

MEDICATIONS (INCLUDING Over-The-Counter)

(Or attach your medication list)

Drug Name and Dosing	Reason for taking

Patient Signature: ___________________________________ **Today's Date:** ______________________

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