

**Rancho ENT
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.** It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcomed to a copy of the report if you wish.

Appointment Date _____

Full Name _____ Male Female Date of Birth _____

Pharmacy Preference (include location) _____

Name of Primary Care (Family) Physician _____ Address _____

Name of Referring Physician (other than primary care physician) _____

Are you taking ANY kind of medication now? (This includes prescription, over-the-counter, Aspirin, Coumadin, blood thinners, or herbal medications)

No Yes If yes, please list below *include dosages.*

| Medication Name | Dosage | How often taken |
|-----------------|--------|-----------------|
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ARE YOU ALLERGIC TO ANY MEDICATIONS? No Yes If yes, please list below.

| Name of Medication | Type of Reaction |
|--------------------|------------------|
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SURGERIES AND HOSPITALIZATIONS

Have you ever had any problems with anesthesia? No Yes

If yes, list types of anesthesia and problems you have had _____

Have you had surgeries including any Ear, Nose or Throat surgeries? No Yes

If yes, list types and when they were done. _____

Have you ever been hospitalized for non-surgical reasons? No Yes

If yes, list dates and reasons _____

What is the main reason you are seeing the doctor today? _____