

**Villa Rica Ear, Nose, & Throat, LLC**  
**ENT Medical History form**

Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Referred by Doctor: \_\_\_\_\_ Pharmacy Phone #: \_\_\_\_\_

Chief Complaint:

What is the reason for this visit: \_\_\_\_\_

Have you ever had/have problems with any of the following: (Please circle yes or no)

Heart Attack	Yes	No	Tuberculosis	Yes	No	Bleeding Disorder	Yes	No
Heart Disease	Yes	No	Pneumonia	Yes	No	Anemia	Yes	No
High Blood Pressure	Yes	No	Kidneys	Yes	No	Thyroid	Yes	No
Chest Pain	Yes	No	Hearing	Yes	No	Ulcers	Yes	No
Stroke	Yes	No	Head Injury	Yes	No	Gallbladder	Yes	No
Seizures	Yes	No	Migraines	Yes	No	Liver-Jaundice,	Yes	No
Lung Disease	Yes	No	Back	Yes	No	Hepatitis	Yes	No
Asthma	Yes	No	Meningitis	Yes	No	Arthritis	Yes	No
Emphysema	Yes	No	Diabetes	Yes	No	Anesthesia	Yes	No
Drink Alcohol	Yes	No	Smoke	Yes	No	Cancer:	Yes	No
Amount: _____			Amount: _____			What: _____		
Pregnant: Yes No						Treatment: _____		
How far: _____								

Please List any operations you have had:

Tonsillectomy/Adenoidectomy: \_\_\_\_\_  
 Ear Tubes/Ear surgery: \_\_\_\_\_  
 Nasal/Sinus: \_\_\_\_\_

Others:

Operation	Date	Surgeon	Hospital
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Medications: \_\_\_\_\_  
 \_\_\_\_\_

Medicines Allergic To: \_\_\_\_\_

Has any blood relative ever had any of the following health problems?

Heart Disease	Yes	No	Tuberculosis	Yes	No	Ulcers	Yes	No
High Blood Pressure	Yes	No	Hepatitis	Yes	No	Asthma	Yes	No
Bleeding disorder	Yes	No	Diabetes	Yes	No	Allergies	Yes	No
Hearing loss	Yes	No	Cancer	Yes	No	Stroke	Yes	No

For Children: Are Immunizations current: \_\_\_\_\_  
 Speech/language delay: \_\_\_\_\_  
 Does anyone in household smoke: \_\_\_\_\_

Signature of Patient (Parent if Minor) \_\_\_\_\_ Date: \_\_\_\_\_