

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)

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

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?

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