East Tennessee Ear, Nose and Throat Specialists, PC

Patient Health History Form

Patient's Last Name: ________________________________ First ____________________________ MI _____

Sex Male Female Date of Birth _________________ Height __________ Weight ___________

Name of Primary Care Physician ____

Pharmacy Preference (include location) ____

REASON FOR TODAY'S VISIT ____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATION? YES NO IF YES, PLEASE LIST BELOW:

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATIONS

Have you ever had any problems with anesthesia (being numbed or put to sleep)? Yes No

If yes, please list type of problems: ____

____

List any surgeries you have had (including dates): ____

____

Have you ever been hospitalized for *non-surgical* reasons? Yes No If yes, please list reason for hospitalizations: ____

____

If you are 50 or over, have you had a colonoscopy? Yes If so, Month _____ Year _____ No

If you are 65 or over, have you had Pneumonia Vaccine Yes If so, Month _____ Year _____ No

CURRENT OR MOST RECENT OCCUPATION ____

10/10/2011