



Patient Medical History

Today's Date: _____ Patient's Name: _____

Birth date: _____ Age: _____ Phone: _____

If patient is under 18 Parent or Legal Guardian: _____

Who does the child live with? _____

List any allergies including medications. What was your body's reaction?:

Were you hospitalized in the last 5 years? If so, please give approximate date and problem:

List your past surgeries: _____

Have you or your immediate family experienced any of the following? (Please circle all that apply)

Malignant Hyperthermia (Inherited disease which causes a rapid rise in body temp & severe muscle contractions when receiving general anesthesia.)

Problems with anesthesia - Description of problems _____

Are you pregnant? Yes / No If so, # of weeks _____

Do you smoke? Yes / No (circle one) How much per day? _____ How many years? _____

When did you quit? _____ Does anyone in your house smoke? Yes / No

Do you Dip or Chew? Yes / No (circle one) How much per day? _____

How many years? _____ When did you quit? _____

Alcohol Consumption: (circle one) daily (how much): _____ occasional social none

Recreational Drugs Yes / No

Do you have or have you had any of the following:

Cardiovascular:

- High blood pressure
- Low blood pressure
- Angina
- Arrhythmia (irregular heartbeat)
- Coronary artery disease
- Rheumatic fever
- STENTS
- High cholesterol
- Congestive Heart Failure
- Heart Attack
- Other _____

Pulmonary:

- Emphysema
- COPD
- Bronchitis
- Pneumonia
- Asthma
- Other _____

Upper Respiratory:

- Nasal septal deformity
- Nasal Polyps
- Seasonal allergies
- Sinus infections
- Sinus headaches
- Nasal Trauma
- Sleep apnea
- Snoring without gasping
- Other: _____

Endocrine / Immune system:

- Diabetes
- Hyperthyroidism (overactive)/Graves Disease
- Hypothyroidism (underactive)
- AIDS / positive HIV
- Autoimmune disease
- Other: _____

Psychiatric:

- ADD/ADHD
- Anxiety
- Depression
- Alzheimers/Dementia
- Other: _____

Skin:

- Eczema
- Psoriasis
- Shingles Location: _____
- Skin Lesions Location: _____
- Other: _____

Ears:

- Ear infections
- Tinnitus (ringing in ears)
- Dizziness or Vertigo
- Menieres Disease
- Hearing Loss
- Sudden Hearing loss
- Labrinthitis
- History of Noise Exposure
- Cholesteatoma
- Acoustic Neuroma/tumors
- Hearing Aid Use
- Other: _____

Gastrointestinal:

- Reflux
- Ulcer
- Other: _____

Neurological:

- Stroke / TIA
- Seizures
- Migraine headaches
- Parkinson's
- Head Trauma
- Other: _____

Hematology:

- Hemophilia (bleeding disorder)
- Blood clotting problems
- Anemia
- Bleed Easily
- Bruise easily
- Nosebleeds
- Other: _____

Past Illness:

- German Measles
- Hepatitis A B C (circle type)
- Mumps
- Sexually Transmitted Disease
Type: _____
- Tuberculosis (TB)
- Cancer Location: _____
- Other infectious Disease : _____
- Other: _____

Musculoskeletal:

- Arthritis
- MS
- Fibromyalgia
- Other: _____

Eyes:

- Cataracts
- Eye Trauma
- Other _____

For Child:

- Full Term Pre Term How Early: _____
- Problems at birth: _____
- Any other Children at home? _____
- Any pets in the house? _____

