Virginia ENT - PATIENT HISTORY

NAME:_____ **DATE OF BIRTH:**_____

REFERRING MD:_____ **PRIMARY CARE MD:**_____

PREFERRED PHARMACY:_____ **LOCATION:**_____

PLEASE STATE THE REASON FOR YOUR VISIT (**Note**: If you are here for **DIZZINESS** please complete the Dizziness Questionnaire before you are called back to see the MD):_____

Are you allergic to any medications? (Please list ALL.) ☐ **None**

FAMILY MEDICAL HISTORY: ☐ **None of these conditions are applicable to my family history** ☐ **unknown family history**

	Mother	Father	Brother	Sister	Grandfather Indicate Maternal/Paternal	Grandmother Indicate Maternal/Paternal
Bleeding Problems						
Anesthesia Difficulty						
Hearing Loss						

MEDICAL & SURGICAL HISTORY: ☐ **None**

(Please list **ALL** of your medical problems & previous surgeries)_____

If you are over 65, have you ever had a Pneumonia Vaccine? _____ Month _____ Year _____ NO_____ N/A

SOCIAL HISTORY:	**YES**	**NO**			
Cigarettes – Never smoked					
Former smoker			Year began:	Year quit:	
Current smoker			Packs per day:	Year began:	
Other Tobacco			Amount per day:	Year began:	Year quit:
Alcohol			Drinks per week:		
Caffeine (soda/coffee)			Drinks per week:		
Day Care Participation					
Cigarette Smoke Exposure					

Do you have or have you been treated for any of the following?

General		**Respiratory**		**Neurological**		**Gastrointestinal**	
Prematurity		Asthma		Meningitis		Heartburn, reflux	
Late development		Chronic cough		Facial pain		Vomiting	
Eating disorders		Sleep apnea		Seizures		Difficulty swallowing	
Fever		Snoring		Dizziness		**Genitourinary**	
Anorexia		**Cardiovascular**		Headaches		Pregnant, currently	
Fatigue		Murmur		Auras		Absence of menstruation	
Significant weight change		Heart defect		Stroke		Prostate problems	
Skin		Irregular heart beat		Fainting		**Hematology**	
Skin cancer		Shortness of breath		**Endocrine**		Abnormal bleeding	
Change in wart/mole		Hypertension		Diabetes		Anemia	
Eyes		Chest pain		Failure to grow		Blood clots	
Double vision		Leg pain or swelling		Thyroid problems		Nose bleeds	
Blurred vision							
Eye pain							

MEDICATIONS

List all medications including over the counter (Please print legibly)

MEDICATION	**DOSE**	**HOW OFTEN ARE YOU TAKING?**