L·E·N·T·S
Louisiana Ear Nose Throat & Sinus

Patient Medical History

Name____ **Date of Birth**__________________
FIRST MIDDLE INITIAL LAST

Were you referred by another provider? If so, by whom:__________________________________

Reason for your visit today:____

PATIENT MEDICAL HISTORY: Have *you* ever had or still have the following (Check for yes):

- ☐ AIDS
- ☐ Alcoholism
- ☐ Allergy Problems
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bell's Palsy
- ☐ Birth Defects
- ☐ Bladder Problems
- ☐ Bleeding Problems
- ☐ Cancer: Type__________ When______________
- ☐ Cholesterol Problems
- ☐ Circulation Problems
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Intestinal Problems
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Lung Problems
- ☐ Meniere's Disease
- ☐ Migraines
- ☐ Mitral Valve Disorder
- ☐ Mononucleosis
- ☐ Nervousness
- ☐ Neurological Problems
- ☐ Sleep Apnea
- ☐ Paralysis
- ☐ Prostate Problems
- ☐ Reflux Problems
- ☐ Seizures
- ☐ Sickle Cell
- ☐ Sinus Problems
- ☐ Sjogren's
- ☐ Skin Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Vertigo

Are you ***allergic to any medication***? ☐ Yes ☐ No Please list:____________________________

____

Are you ***currently taking any medications***? ☐ Yes ☐ No Please list & include dosage (use back of this page if more space needed):____

____

If you are 65 or older have you had a ***pneumonia vaccine***? ☐ Yes ☐ No If Yes, when (if known)________________

Have you had a ***flu vaccine*** this year? ☐ Yes ☐ No If Yes, please list date (if known)____________________

Do you have an ***Advance Directive or Living Will***? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No if yes, due date?____________________ and/or breastfeeding? ☐ Yes ☐ No

PAST SURGICAL HISTORY
Please list any past surgical procedures: ____

____

FAMILY HISTORY: Have any immediate blood relatives had the following? (specify relation, i.e. mother, etc):

- ☐ Asthma_______________________
- ☐ Bleeding Problems_______________
- ☐ Cancer_______________________
- ☐ Diabetes______________________
- ☐ Epilepsy______________________
- ☐ Glaucoma_____________________
- ☐ Heart Disease__________________
- ☐ High Blood Pressure ______________
- ☐ Stroke_______________________
- ☐ Thyroid Problems_______________
- ☐ Tuberculosis__________________

SOCIAL HISTORY:
Tobacco Use (circle one): Current / Former / Never What type(s): Cigarettes / Cigars / Pipe / Snuff / Chew / Vape

How much/often?__________________When did you: Start?__________________ Quit?_______________

Alcohol Use: ☐ Yes ☐ No If Yes, how much and how often?________________ Drug Use: Current / Former / Never

Signature:____ Date:__________________