OTOLARYNGOLOGY HEAD & NECK SURGERY

HEALTH HISTORY FORM

PLEASE PRINT

PAST MEDICAL HISTORY

Prior illnesses _____
_____
Current medications _____
_____
Allergies to medications _____
_____
Prior surgery _____
_____
Injuries _____
_____
Hospitalizations _____
_____

FAMILY MEDICAL HISTORY (Health problems, similar illnesses, related hereditary illnesses)

Parents _____
Siblings _____
Relatives _____

SOCIAL HISTORY

Marital status: single ___ married ___ separated ___ divorced ___ widowed ___
Alcohol intake: never ___ rarely ___ moderate ___ daily ___
Tobacco use: never ___ previously, but quit ___ current packs/day ___
Pregnant: yes ___ no ___
Current occupation: _____

REVIEW OF MEDICAL SYSTEMS (Check if normal, otherwise write in symptoms on line provided)

☐ Cardiovascular _____
☐ Gastrointestinal _____
☐ Musculoskeletal _____
☐ Neurological _____
☐ Psychiatric _____
☐ Ear/Nose/Throat _____
☐ Respiratory _____
☐ Skin _____
☐ Allergy/Immunologic _____
☐ Eyes _____

PATIENT SIGNATURE _____ **DATE** _____

PHYSICIAN REVIEWED _____ **DATE** _____

PHYSICIAN UPDATED _____ **DATE** _____

PHYSICIAN UPDATED _____ **DATE** _____