

PAST MEDICAL HISTORY

Name: _____ Date of Birth: _____ Date: _____

Reason for visit: _____

List hospitalizations/serious injuries and dates: _____

Medications: _____

Allergies to medications: _____

Previous Surgeries

Yes No Tonsillectomy and adenoidectomy / date(s): _____

Yes No Myringotomy and tubes. If yes, how many times? _____

Yes No Sinus and nasal surgeries. Please state type, date and physician for each surgery:

Yes No Ear surgeries / date(s): _____

Yes No Other surgeries / date(s): _____

Family History

Bleeding disorders: _____

Asthma/allergies: _____

Diabetes: _____

Hearing loss: _____

Occupation: _____

Social History

Yes No Quit **Smoking** _____ packs a day for _____ years. If you have quit, explain history:

Yes No Quit **Alcohol** _____ drinks/beers per week. If you have quit, explain history:

Yes No Quit **Caffeine** _____ cans of caffeinated soda per day; _____ cups of coffee per day