

MECKLENBURG EAR NOSE & THROAT

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

FAMILY DOCTOR: \_\_\_\_\_

**PAST MEDICAL HISTORY**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> HEART DISEASE                       | <input type="checkbox"/> EMPHYSEMA               | <input type="checkbox"/> LIVER DISEASE/HEPATITIS |
| <input type="checkbox"/> DIABETES                            | <input type="checkbox"/> BLOOD CLOTS             | <input type="checkbox"/> HIV/AIDS                |
| <input type="checkbox"/> HIGH BLOOD PRESSURE                 | <input type="checkbox"/> CANCER                  | <input type="checkbox"/> OTHER _____             |
| <input type="checkbox"/> STROKE                              | <input type="checkbox"/> GOUT                    | _____  |
| <input type="checkbox"/> ASTHMA                              | <input type="checkbox"/> MENOPAUSE               |  |
| <input type="checkbox"/> THYROID TROUBLE                     | <input type="checkbox"/> OSTEOPOROSIS            |  |
| <input type="checkbox"/> SICKLE CELL TRAIT/DISEASE           | <input type="checkbox"/> HYPOPARATHYROIDISM      |  |
| <input type="checkbox"/> TREATMENT FOR DRUG OR ALCOHOL ABUSE |  |  |
| <input type="checkbox"/> KIDNEY DISEASE                      | <input type="checkbox"/> HIGH CHOLESTEROL        |  |
| <input type="checkbox"/> LIVER DISEASE                       | <input type="checkbox"/> RHEUMATOID ARTHRITIS    |  |
| <input type="checkbox"/> SEIZURES                            | <input type="checkbox"/> DEPRESSION              |  |
| <input type="checkbox"/> ULCERS                              | <input type="checkbox"/> MENTAL HEALTH DISORDERS |  |
| <input type="checkbox"/> BLEEDING DISORDER                   | <input type="checkbox"/> ANESTHESIA REACTION     |  |

**FAMILY MEDICAL HISTORY**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> HEART DISEASE                       | <input type="checkbox"/> EMPHYSEMA               | <input type="checkbox"/> LIVER DISEASE/HEPATITIS |
| <input type="checkbox"/> DIABETES                            | <input type="checkbox"/> BLOOD CLOTS             | <input type="checkbox"/> HIV/AIDS                |
| <input type="checkbox"/> HIGH BLOOD PRESSURE                 | <input type="checkbox"/> CANCER                  | <input type="checkbox"/> OTHER _____             |
| <input type="checkbox"/> STROKE                              | <input type="checkbox"/> GOUT                    | _____  |
| <input type="checkbox"/> ASTHMA                              | <input type="checkbox"/> MENOPAUSE               |  |
| <input type="checkbox"/> THYROID TROUBLE                     | <input type="checkbox"/> OSTEOPOROSIS            |  |
| <input type="checkbox"/> SICKLE CELL TRAIT/DISEASE           | <input type="checkbox"/> HYPOPARATHYROIDISM      |  |
| <input type="checkbox"/> TREATMENT FOR DRUG OR ALCOHOL ABUSE |  |  |
| <input type="checkbox"/> KIDNEY DISEASE                      | <input type="checkbox"/> HIGH CHOLESTEROL        |  |
| <input type="checkbox"/> LIVER DISEASE                       | <input type="checkbox"/> RHEUMATOID ARTHRITIS    |  |
| <input type="checkbox"/> SEIZURES                            | <input type="checkbox"/> DEPRESSION              |  |
| <input type="checkbox"/> ULCERS                              | <input type="checkbox"/> MENTAL HEALTH DISORDERS |  |
| <input type="checkbox"/> BLEEDING DISORDER                   | <input type="checkbox"/> ANESTHESIA REACTION     |  |

**PATIENT SOCIAL HISTORY**

SMOKE \_\_\_\_\_ PACKS PER WEEK      DRINK ALCOHOL \_\_\_\_\_ DRINKS PER WEEK  
HISTORY OF SMOKING \_\_\_\_\_ HOW MUCH? \_\_\_\_\_  
OCCUPATION \_\_\_\_\_  
CAFFEINE (I.E. COFFEE, SODA, ECT.) \_\_\_\_\_

**SURGICAL HISTORY**

PROCEDURE(S) AND DATE(S)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DRUG ALLERGIES/REACTIONS**

Check if no allergies   
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

REACTION TO ANESTHESIA OR LATEX  Y  N  
IF YES, DESCRIBE \_\_\_\_\_

**MEDICATIONS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_