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Marshall ENT & Allergy

PATIENT HEALTH HISTORY

PLEASE COMPLETE EVERY ITEM.

Patient's Name (First, Last, MI) _____

Family Physician _____ **Referring Physician** _____

Pharmacy Preference (include location) _____

REASON FORTODAY'S VISIT _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING. (Please include BLOOD THINNERS, SUPPLEMENTS & VITAMINS, and OVER-THE-COUNTER MEDICATIONS).

Name of Medication	Dose	Frequency

ARE YOU CURRENTLY TAKING ALLERGY INJECTIONS? ❒ YES ❒ NO

ARE YOU NOW USING A CPAP MACHINE? ❒ YES ❒ NO

ARE YOU ALLERGIC TO ANY MEDICATION? ❒ YES ❒ NO **If yes, please list below:**

Name of Medication	Type of Reaction (Ex. Rash, Nausea, Vomiting, Other)

SURGERIES AND HOSPITALIZATIONS

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ❒ YES ❒ NO

If Yes, please list types of problems:

Have you been hospitalized in the last 3 months? ❒ YES ❒ NO

If yes, list reason:

CURRENT OR MOST RECENT OCCUPATION: _____