ENT ASSOCIATES OF CENTRAL PA

PATIENT HEALTH HISTORY

Patient Name :_____ Date of Birth: ____/____/____ Height:_____ Weight:_____

Pharmacy (Include Location):_____

Reason for today's visit: _____

_____

Have you ever been treated with chemo or radiation therapy? ___No ___Yes—When? _____

ARE YOU TAKING ANY **MEDICATIONS** NOW? ___NO ___YES PLEASE LIST BELOW AND INCLUDE DOSAGES ☐ **SEE LIST**

Medication	Dosage	How Often	Medication	Dosage	How Often

ARE YOU **ALLERGIC** TO ANY MEDICATIONS? ___NO ___YES PLEASE LIST BELOW AND INCLUDE REACTION ☐ **SEE LIST**

Medication Name	Reaction	Medication Name	Reaction

HAVE YOU HAD ANY **SURGERIES**? ___NO ___YES PLEASE LIST BELOW AND INCLUDE DATES ☐ **SEE LIST**

Type of Surgery	Date	Type of Surgery	Date

HAVE YOU BEEN **HOSPITALIZED** FOR NON SURGICAL REASONS? ___NO ___YES PLEASE LIST BELOW AND INCLUDE DATES ☐ **SEE LIST**

Reason Hospitalized	Date	Reason Hospitalized	Date

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS: (Please check all that apply)

Heart Attack ☐ Heart Disease ☐ High Blood Pressure ☐

Diabetes ☐ Stroke ☐ Pneumonia ☐

Problems with Anesthesia ☐ Please Explain: _____

Bleeding/ Clotting Problems ☐ Please Explain: _____

Other: _____

_____ _____

SIGNATURE OF PATIENT/ LEGAL GUARDIAN DATE