Central ENT Consultants, PC

Form updated 12/11/2020

PATIENT HEALTH HISTORY

NAME:_____ DOB: ____ / ____ / ____ Pharmacy:_____

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.**

CURRENT MEDICATIONS: Are you taking ANY kind of medication? (This includes prescription, over-the-counter or herbal medications.) **YES** If yes, please list below. **NO**

MEDICATION NAME	DOSAGE	HOW OFTEN TAKEN

MEDICATION ALLERGIES: Are you allergic to any medications? **YES** If yes, please list below. **NO**

MEDICATION NAME	TYPE OF REACTION (Rash, swelling, etc.)

MEDICAL PROCEDURES: Have you had any surgery or medical procedures? **YES** If yes, list below. **NO**

Type					
Month / Year					

Type	Colonoscopy	Flu shot	Pap Smear	Pneumonia Vaccine	Mammogram
Month / Year					

Have you had any serious injuries or accidents that we need to know about?_____

_____