Patient Name: _____ **DOB:** _____

In order for us to obtain a complete medical history, it is important for you to fill out this form completely.

CURRENT MEDICATION/supplements, including dosage:

_____
_____
_____

MEDICAL HISTORY: (Please circle if you have any of the following conditions)

Acid reflux Asthma Cancer Diabetes Heart Disease Hypertension HIV/AIDS
Hearing loss Sleep apnea Thyroid problems Meniere's Von Willebrand

Other: _____

ALLERGIES/INTOLERANCE:

_____
_____

SURGICAL HISTORY:

_____
_____
_____

FAMILY HISTORY: (Please circle all that apply)

Hearing Loss Cancer Diabetes Asthma Heart Disease Hypertension Thyroid Problems Bleeding Disorders Multiple Sclerosis Meniere's

SOCIAL HISTORY: (Please answer YES or NO to the following)

Alcohol use Y N Tobacco use Y N Former tobacco use Y N Smoke Marijuana Y N
Recreational drug use Y N

GENERAL: (circle all that apply)

Fatigue Headaches Lightheadedness Sleep Disturbance

ALLERGY:(circle all that apply)

Postnasal drainage Running nose Nasal congestion Cough Seasonal Allergies Sneezing
Watery Eyes Reaction to anesthesia

ENT: (circle all that apply)

Chronic Sinusitis Nasal Polyps Blocked Ear Decreased Hearing Decreased sense of smell/taste
Deviated septum Difficulty swallowing Dry mouth Ear Pain Ear Problems
History of broken nose Mouth breathing Nosebleeds Ringing in ear(s)
Sinus pain/pressure Snoring Sore throat Swollen Glands

ENDOCRINE: (circle all that apply)

Goiter Abnormal weight gain/loss Diabetes Difficulty sleeping Dizziness Hair loss Weakness