Villa Rica
Ear, Nose & Throat

Medical History Form

Name_______________ Age:_______ Date of Birth:_______________

Referred by:_______________ Pharmacy Phone #:_______________

Pharmacy Name and Address:_______________

Reason for your visit today/symptoms:_______________

Have you ever been diagnosed with: (circle)

Acid Reflux	no	yes	High blood pressure	no	yes	Speech Delay	no	yes
Allergies	no	yes	HIV	no	yes	Stroke	no	yes
Asthma	no	yes	Hypo/Hyper Thyroid	no	yes	TMJ	no	yes
Autism/Asperger's	no	yes	Kidney disease	no	yes	Vascular disease	no	yes
Blood disorder	no	yes	Liver disease	no	yes	Other:_______		
Cancer	no	yes	Meniere's Disease	no	yes	Other:_______		
Diabetes	no	yes	Migraines	no	yes	Other:_______		
Hearing Impairment	no	yes	Pneumonia	no	yes	Other:_______		
Heart Condition	no	yes	Seizures	no	yes	Other:_______		
Hepatitis	no	yes	Sleep Apnea	no	yes	Other:_______		

Have you ever had any of the following surgeries: (circle)

Ear, Nose, and Throat:			***Date:***	***Other:***	***Date:***	***Type:***
Adenoidectomy	no	yes	_______	Heart	_______	_______
Ear surgery	no	yes	_______	Pace Maker		yes no
Frenulectomy	no	yes	_______	Kidney	_______	_______ Dialysis? Yes No
Nasal surgery	no	yes	_______	Ortho	_______	_______
PE(ear)tubes	no	yes	_______	Metal implants		Where?_______
Sinus surgery	no	yes	_______	Cancer	_______	_______
Thyroid surgery	no	yes	_______	Other:	_______	
Tonsillectomy	no	yes	_______	Other:	_______	
Throat surgery	no	yes	_______	Other:	_______	
Other: _______				Other:	_______	

Current Prescription Medications:

_______ _______
_______ _______
_______ _______
_______ _______
_______ _______
_______ _______

Drug Allergies:			***Other:***
No Known Drug Allergies			_______
Penicillins	no	yes	_______
Sulfa	no	yes	_______
Latex	no	yes	_______
IVP dyes	no	yes	_______
Rocephin	no	yes	_______

Family Medical History-Blood Relatives (circle)

Allergies	Cancer	Hearing Loss	Hepatitis	Stroke
Asthma	Diabetes	Heart Disease	High Blood Pressure	Other:_______

Do you drink alcohol? no yes rarely monthly daily

Drug addiction? no yes former current

Do you use tobacco? no yes former smoke ecig/vapor dip

Children: Are Immunizations current? yes no Never immunize

Women: Are you pregnant? no yes ***Breast Feeding?*** no yes

Signature of Patient (parent/guardian if under 18)_______________

(If you are the patient's guardian, please give all legal documentation to the front desk)