

**THIS FORM MUST BE COMPLETED (Front & Back) PRIOR TO YOUR ARRIVAL AND MAILED TO OUR OFFICE OR FAXED TO 213-3895**

**COMMONWEALTH EAR, NOSE & THROAT- HEAD & NECK CENTER  
PATIENT MEDICAL HISTORY**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_ Appt Date \_\_\_\_\_ SS# \_\_\_\_\_

Main reason for today's visit \_\_\_\_\_

Which Physician requested this consultation? \_\_\_\_\_  
(First and Last Name)

Name of Primary Care Physician/Pediatrician (if different)? \_\_\_\_\_  
(First and Last Name)

**PERSONAL MEDICAL HISTORY**

Does the patient have any of the following conditions? Please circle.

- |                          |                           |                                |
|--------------------------|---------------------------|--------------------------------|
| Allergies to Environment | Heart Murmur              | Pneumonia                      |
| Allergies to Food        | Heart Valve Disease       | Rheumatic Fever                |
| Allergies to Latex       | Hiatal Hernia             | Sickle Cell Hb-C Disease       |
| Anemia                   | High Blood Pressure       | SLE (Lupus)                    |
| Anesthesia Problems      | High Cholesterol          | Stroke                         |
| Asthma                   | History of Cancer         | Thyroid Problems               |
| Bleeding Problems        | History of Kidney Stones  | No Significant Medical History |
| Chicken Pox              | History of MRSA           |                                |
| Exposure to Tuberculous  | Jaundice                  |                                |
| Diabetes                 | Liver Infection/Hepatitis |                                |
| Emphysema or COPD        | Low Blood Sugar           |                                |
| Gastroesophageal Reflux  | Malaria                   |                                |
| On C-PAP for Sleep Apnea | Measles                   |                                |
| Heart Attack             | Mumps                     |                                |

Does the patient have any other medical conditions not listed above? (If yes please describe below)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any surgery the patient has had (include childhood surgery such as tonsillectomy and include any surgery performed by Commonwealth Ear Nose & Throat)

<b>Surgery</b>	<b>Date</b>	<b>Surgeon/Hospital</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

**MEDICATION**

Does the patient take any prescribed medicines or over the counter medicines? No Yes (if yes, list below)

Medication	Dosage	Duration (How Long?)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does the patient use any of the following: (please circle any that apply)

Aspirin    Ibuprofen    Naprosyn    Nasal Sprays

How often? \_\_\_\_\_ Brand name? \_\_\_\_\_

Is the patient ALLERGIC to any medications? No Yes (If yes, list below)

Name of medicine	Type of reaction
_____	_____
_____	_____
_____	_____

**IMMEDIATE FAMILY HISTORY** (Immediate family = parents and siblings)

- |   |                                      |   |  |
|---|--------------------------------------|---|--|
| <input type="checkbox"/> Adoption               | <input type="checkbox"/> Allergies   | <input type="checkbox"/> Asthma         | <input type="checkbox"/> Bleeding Problems   |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Foster Care | <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> High Cholesterol Level | <input type="checkbox"/> Stroke      | <input type="checkbox"/> Sugar Diabetes | <input type="checkbox"/> Thyroid Cancer      |
| <input type="checkbox"/> No Significant History |                                      |   |  |

**SOCIAL HISTORY** (Please check ALL that apply to the patient)

- |   |   |
|---|---|
| <input type="checkbox"/> A Living Will          | <input type="checkbox"/> Non Smoker           |
| <input type="checkbox"/> Alcohol abuse          | <input type="checkbox"/> Non-drinker          |
| <input type="checkbox"/> Alcohol use            | <input type="checkbox"/> Pet, cat             |
| daily _____                                     | <input type="checkbox"/> Pet, dog             |
| weekly _____                                    | <input type="checkbox"/> Smoke exposure       |
| socially _____                                  | <input type="checkbox"/> Smoker               |
| <input type="checkbox"/> Alcohol, quit _____    | <input type="checkbox"/> Smoker-.05 pack/day  |
| how many years? _____                           | <input type="checkbox"/> Smoker- 1 pack/day   |
| when did you quit? _____                        | <input type="checkbox"/> Smoker- 2 packs/day  |
| <input type="checkbox"/> Daycare                | <input type="checkbox"/> Smoker- 2+ packs/day |
| <input type="checkbox"/> Daycare not attended   | <input type="checkbox"/> Smoker, quit         |
| <input type="checkbox"/> No Smoke Exposure      | how many years _____                          |
| <input type="checkbox"/> No smoking in the home | when did you quit _____                       |
|   | Amount per day you use to smoke _____         |

**Please note any changes since your last visit:**

**Changes in allergies, i.e. medication, food or environment** \_\_\_\_\_

Changes in medication \_\_\_\_\_

Any new surgeries \_\_\_\_\_

**Please check any of the following conditions that apply to the patient:**

Eyes:                     Changes in vision                     Double vision

Breasts:                 Nipple discharge                     Nipple tenderness

GI:                       Constipation                       Abdominal pain

GU:                     Difficulty voiding                     Pregnancy/Possible pregnancy  
                           Painful urination

Skin:                     Rash                                     New Skin Lesions

Neurologic:            Tremors                                Seizures

Musculoskeletal:    Joint Swelling                     Muscle Pain

Endocrine:             Excessive Sweating                Loss of Hair

Psychiatric:          Anxiety                                Depression

Heme-Lymph:         Easy Bleeding                     Easy Bruising

**Place a check here if NONE of the conditions above apply to the patient**