

MEDICAL HISTORY

NAME: _____ DATE: _____

HAVE YOU EVER HAD:

YES	NO		YES	NO	
_____	_____	HEART DISEASE	_____	_____	HEART MURMUR
_____	_____	HIGH BLOOD PRESSURE	_____	_____	COUGHING UP BLOOD
_____	_____	STROKE	_____	_____	CHRONIC LUNG CONDITION
_____	_____	KIDNEY DISEASE	_____	_____	ASTHMA
_____	_____	TUBERCULOSIS	_____	_____	THYROID TROUBLE
_____	_____	CANCER	_____	_____	UNCONSCIOUSNESS FOR ANY REASON
_____	_____	LIVER DISEASE	_____	_____	SEVERE HEAD INJURY
_____	_____	JAUNDICE / HEPATITIS	_____	_____	STOMACH TROUBLE / ULCER
_____	_____	ANEMIA / BLOOD DISEASE	_____	_____	DIABETES
_____	_____	SYPHILIS			
_____	_____	HIV			

DO YOU HAVE OR ARE YOU CURRENTLY HAVING TROUBLE WITH ANY OF THE FOLLOWING:

_____	_____	FREQUENT EAR INFECTIONS	_____	_____	HOLE IN EITHER EARDRUM
_____	_____	FREQUENT RESPIRATORY INFECTIONS	_____	_____	DRAINING FROM EITHER EAR
_____	_____	FREQUENT SINUS TROUBLE	_____	_____	PERSISTENT HOARSENESS
_____	_____	DIZZY SPELLS OR FAINTING	_____	_____	LUMPS OR SWELLING IN NECK
_____	_____	DIFFICULTY IN HEARING	_____	_____	DIFFICULTY IN SWALLOWING
_____	_____	RINGING OR NOISE IN THE EARS			

WHAT IS YOUR CHIEF COMPLAINT TODAY? _____

DO YOU HAVE ANY DRUG ALLERGIES? YES NO
IF YES, LIST BELOW.

DO YOU HAVE ANY ALLERGIES OTHER THAN TO MEDICATION? YES NO
IF YES, LIST BELOW.

ARE YOU CURRENTLY TAKING ANY MEDICATION? YES NO
IF YES, LIST BELOW.

HAVE YOU HAD ANY PREVIOUS SURGERY? YES NO
IF YES, LIST BELOW: