EASTERN VIRGINIA EAR, NOSE AND THROAT SPECIALISTS
MEDICAL HISTORY FORM

Name: _____ **Today's Date**: _____
Date of Birth: _____ **Family Doctor/PCP**: _____
Pharmacy Name: _____ **Pharmacy Phone Number**: _____
Pharmacy Address: _____
Preferred Language: _____ **Occupation:** _____
Marital Status: ____ Married ____ Single ____ Widowed ____ Divorced
Race: ____ White ____ African American ____ Asian ____ American Indian ____ Pacific Islander
____ Other ____ Decline to Answer
Ethnicity: ____ Hispanic ____ Non-Hispanic ____ Decline to Answer

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MEDICAL PROBLEMS

PLEASE CHECK IF YOU HAVE EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS

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- ☐ Allergies
- ☐ Asthma
- ☐ Dizziness
- ☐ Ear Infections
- ☐ Eustachian Tube Dysfunction
- ☐ Hearing Loss
- ☐ Meniere's disease
- ☐ Nasal Polyp
- ☐ Neck Mass
- ☐ Parotid Gland Abnormality
- ☐ Perforated Ear Drum
- ☐ Reflux/GERD
- ☐ Sinusitis
- ☐ Sleep Apnea
- ☐ Thyroid Gland Abnormality
- ☐ Tinnitus
- ☐ Tonsillitis
- ☐ Other: _____

GENERAL MEDICAL

- ☐ Anemia
- ☐ Arthritis
- ☐ Birth Defects
- ☐ Cancer
- ☐ Diabetes
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hypertension (High Blood Pressure)
- ☐ Hepatitis
- ☐ HIV
- ☐ Osteoporosis
- ☐ Seizures
- ☐ Tuberculosis
- ☐ Urinary Problems
- ☐ Venereal Disease
- ☐ Skin Disease
- ☐ Stroke

ALLERGIES TO MEDICATION

PLEASE LIST ALL OF YOUR MEDICATION ALLERGIES AND REACTIONS	☐ **NO KNOWN ALLERGIES (CHECK)**

Do you have an allergy to Latex? ____ Yes ____ No
Do you have an allergy to Intravenous Dye? ____ Yes ____ No
Do you have any allergies to foods? ____ Yes ____ No Please list: _____

FAMILY HISTORY

____ Bleeding Disorder ____ Thyroid Disorder ____ Cancer ____ Allergy ____ Asthma

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SOCIAL HISTORY

Tobacco Use: ____ Yes ____ No ____ Former

____ Cigarettes ____ Pipe ____ Cigars ____ Smokeless ____ Chewing

Packs/Day: _____ How many years have you smoked: ____

Do you smoke daily: ____ Yes ____ No

Tried to Quit: ____ Yes ____ No Year you Quit: _____

Are you exposed to second hand smoke: ____ Yes ____ No

Alcohol Use: ____ Yes ____ No

____ Beer ____ Wine ____ Liquor

How often do you drink: ____ Daily ____ Weekly ____ Monthly ____ Rarely

Amount: _____

Recreational Drug Use: ____ Yes ____ No If yes, what type: _____

P**ets**: ____ Dog ____ Cat ____ Horse ____ Bird Other, please list: _____

Are you currently pregnant: ____ Yes ____ No If Yes, how many weeks: _____

MEDICATIONS

PLEASE LIST ALL OF YOUR CURRENT MEDICATIONS	☐ **NO MEDICATIONS (CHECK)**

SURGICAL HISTORY

PLEASE LIST YOUR SURGICAL HISTORY AND DATE OF SURGERY	☐ **NO SURGICAL HISTORY (CHECK)**