

**ATLANTA CHILDREN'S ENT, P.C.
PATIENT HEALTH HISTORY**

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. Please fill out every item. It is important for you doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcomed to copy the report if you wish.

Full Name _____ **Male** ___ **Female** ___ **Race** ___ **Date of Birth** _____

Pharmacy Location _____ **Pharmacy Telephone Number** _____

Name of Primary Care (Family) Physician _____
Address and Telephone Number _____

Are you taking any kind of medication now? (This includes prescription, over-the-counter or herbal medications.)
No ___ Yes ___, if yes please include dosages.

Medication Name and Dosage	Problem being treated	Date of Prescription	Prescribing Doctor

Are you allergic to any medications? No ___ Yes ___, if yes please list below.

Name of Medication	Type of Reaction

Are you allergic to anything in the environment such as pollen, dust, food, etc.. No ___ Yes ___
If yes, please indicate what you are allergic to.

Have you ever had an allergy test? No ___ Yes, if yes when _____

Have you ever been DIAGNOSED with any major health problems? Including but not limited to:

Cancer (Type) _____ No ___ Yes, if yes, when _____

Nose and Sinus:

Nasal Allergies No ___ Yes ___ if yes, when _____

Heart and Blood Vessels:

High/Elevated Cholesterol No ___ Yes ___ if yes, when _____

High Blood Pressure No ___ Yes ___ if yes, when _____

Lungs and Respiratory:

Tuberculosis No ___ Yes ___ if yes, when _____

Stomach/digestive No ___ Yes ___ if yes, when _____

Duodenal ulcer No ___ Yes ___ if yes, when _____

Hepatitis No ___ Yes ___ if yes, when _____

Stomach ulcer No ___ Yes ___ if yes, when _____

Are you pregnant? No ___ Yes ___

Mental & Emotional:

Depression No ___ Yes ___ if yes, when _____

Anxiety No ___ Yes ___ if yes, when _____

Glands, Hormones & Sugar Control:

Diabetes No ___ Yes ___ if yes, when _____

Thyroid deficiency No ___ Yes ___, if yes, when _____

Thyroid excess No ___ Yes ___ if yes, when _____

Blood & Lymph Node problems:

Anemia No ___ Yes ___ if yes, when _____

Allergies, Immune & Infectious:

HIV No ___ Yes ___ if yes, when _____

Infectious mononucleosis No ___ Yes ___ if yes, when _____

Have you ever been DIAGNOSED with any other major health problem not listed above? No ___ Yes ___ if yes please list diagnosed and the year was made.

SURGERIES AND HOSPITALIZATIONS

Have you ever been hospitalized for a medical problem before? No ___ Yes ___
If yes, list hospitalization, the reason for admission and the date.

Have you ever had *SURGERY*? No ___ Yes ___
If yes list any surgeries and when they were done.

Have you ever had any problems with anesthesia (being numbed or put to sleep)? No ___ Yes ___
If yes please list what sort of problems.

PATIENT'S FAMILY HISTORY (Please circle the proper answer)

Specific Anesthesia Problems	Mother	Father	Brother	Sister	Lung Cancer	Mother	Father	Brother	Sister
Hearing Loss before age 20	Mother	Father	Brother	Sister	Breast Cancer	Mother	Father	Brother	Sister
Hearing Loss after age 20	Mother	Father	Brother	Sister	Skin Cancer	Mother	Father	Brother	Sister
Nasal Allergies	Mother	Father	Brother	Sister	Stroke	Mother	Father	Brother	Sister
Heart Disease	Mother	Father	Brother	Sister	Bleeding/clotting	Mother	Father	Brother	Sister
High Blood Pressure	Mother	Father	Brother	Sister	Asthma	Mother	Father	Brother	Sister
Other _____	Mother	Father	Brother	Sister					

SOCIAL HISTORY

Is patient exposed to second hand smoke? No ___ Yes ___
Is patient in Day Care? No ___ Yes ___

REVIEW OF SYSTEMS(Have you had or have you recently has any?)

General health problems? No ___ Yes ___
(fever, weight loss, problems sleeping, etc)
If yes, please list _____

Stomach problems? No ___ Yes ___
(pain, heartburn, nausea, vomiting, diarrhea, etc)
If yes, please list _____

Head or face problems? No ___ Yes ___
(headache, face pain, etc.)
If yes, please list _____

Kidney bladder or gender related problems No ___ Yes ___
If yes, please list _____

Ear problems? No ___ Yes ___
(drainage, hearing loss, ringing, dizziness, etc)
If yes, please list _____

Skin Problems No ___ Yes ___
(rashes)
If yes, please list _____

Nose and sinus problems? No ___ Yes ___
If yes, please list _____

Brain/nervous system problems? No ___ Yes ___
If yes, please list _____

Mouth and throat problems? No ___ Yes ___
(frequent sore throat, mouth sores, hoarseness, etc)
If yes, please list _____

Mental or emotional problems? No ___ Yes ___
If yes please list _____

Neck problems? No ___ Yes ___
(Lumps, masses, pain, swollen glands, etc.)
If yes, please list _____

Problems bleeding? No ___ Yes ___
(Bleeding freely, bruising excessively, other blood problems)
If yes, please list _____

Lung or respiratory problems? No ___ Yes ___
(wheezing, shortness of breath, frequent cough, etc)
If yes, please list _____

Allergies or frequent infections in different areas of patient body? No ___ Yes ___
If yes, please list _____

Eye problems that are not correct with glasses?
(double vision, glaucoma, cataracts, etc,) No ___ Yes ___
If yes, please list _____