SOUTHERN UTAH EAR NOSE THROAT AUDIOLOGY ALLERGY & FACIAL PLASTICS

Medical History Intake Form

Patient Name: _____ **Birth Date**: _____

Today's Date: _____

Reason/symptoms for today's visit: _____

Please list any chronic illnesses or diseases you have: _____

_____

List all previous surgeries:

_____

_____

Do you have HEART PROBLEMS? YES OR NO Are **you on any BLOOD THINNERS? YES** OR NO

If so, what type of heart problems? _____ **If so, name of blood thinner:** _____

Do you have a pacemaker or any artificial heart device? YES OR NO

History of cancer? _____

History of family cancer or additional comments:

_____

Are you allergic to any medications?

_____

Please list any medications you are currently on or please circle <u>See Attached List</u> if you provided one:

_____

_____

_____

_____

Are you currently on a pain medicine contract with any other clinic? **Yes or No Clinic Name** _____

<u>Social History:</u> Do you smoke or use tobacco? **YES or NO** Do you drink alcohol? **YES or NO**

<u>ENT history</u>: Do you have? (please circle)

Loss of vision	Ringing in ears		
Eye pain	Dizziness	Facial pain	Thyroid problems
Headaches	Hoarseness	Nasal Congestion	Ear pain
Ear drainage	Sore mouth/throat	Snoring	Voice change

Patient or legal guardian signature: _____