Century
ear · nose & throat

Patient History

Name:_____ DOB:_____/_____/_____

Pharmacy Name:_____Location:_____ Phone: (_____)_____-_____

Who is your primary care doctor:

Name:_____

Address:_____

_____

Phone:_____

How did you hear about our practice?

- ○ Family or Friends
- ○ Physician Dr._____
- ○ Hospital
- ○ Insurance
- ○ Internet

Do you or any of your family members have any of the following?	***Myself***	***Immediate Relative***	***Neither***
Bleeding Tendency	☐	☐	☐
Diabetes	☐	☐	☐
High blood Pressure	☐	☐	☐
Heart disease	☐	☐	☐
Asthma/Emphysema	☐	☐	☐
Skin problems	☐	☐	☐
Cancer, Type:_____	☐	☐	☐
Hepatitis/ Liver Disease	☐	☐	☐
Thyroid Disease	☐	☐	☐
Kidney Disease	☐	☐	☐
Seizures or Stroke	☐	☐	☐
Infectious disease	☐	☐	☐
Congenital or Genetic Disorder	☐	☐	☐
Ringing/ Buzzing in Ears	☐	☐	☐
Hearing Loss	☐	☐	☐
Allergies/Hay Fever	☐	☐	☐
Previous Allergy Testing	☐	☐	☐
Any adverse reaction to Anesthesia	☐	☐	☐

Other_____

Please Complete:

Height:_____ Weight:_____

Please list medications you take:

_____

_____

_____

_____

_____

_____

_____

_____

Please list any allergies to medications: ☐ ***None***

_____

_____

_____

Please list any previous overnight hospitalizations and surgeries related to Ear, Nose, Throat, and Heart ☐ ***None***

_____

_____

_____

_____

_____

_____

Do you smoke?_____ **How much?**_____**Do you drink?**_____**How much?**_____

I hereby certify that to the best of knowledge the provided information is true and accurate:

Patients signature or responsible guardian:_____

For office use only: Reviewed by: Date: