Valley ENT, Allergy, and Cosmetic Surgery
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 your doctor to know you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Patient's Last Name _____First _____ MI _____

Sex ☐ Male ☐ Female Date of Birth: _____ HT:_____ WT:_____

Name of Primary Care Physician: _____

Pharmacy Preference (include location): _____

REASON FOR TODAY'S VISIT: _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATION? ☐ No ☐ Yes If yes, please list below:

Name of Medication	Type of Reaction

MEDICAL HISTORY/SURGERIES/HOSPITALIZATIONS.

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ No ☐ Yes

If yes, what type of problems did you experience?_____

Have had any ear, nose or throat procedures? ☐ No ☐ Yes (type and date)_____

_____

Have had other surgery? ☐ No ☐ Yes (type and dates)_____

_____

Have you ever been hospitalized for non-surgical reasons? ☐ No ☐ Yes

If yes, list reasons for hospitalizations _____

_____

Have you had a recent flu shot? ☐ No ☐ Yes (date)_____

Have you had the pneumonia vaccine? ☐ No ☐ Yes (date)_____

Have you had a recent colonoscopy? ☐ No ☐ Yes (date)_____

If female, have you had a recent mammogram? ☐ No ☐ Yes (date)_____

If female, have you had a recent pap test? ☐ No ☐ Yes (date)_____

CURRENT OR MOST RECENT OCCUPATION: _____

*Please proceed to the next page.