

NY Center For
Ear, Nose Throat, Sinus & Allergy, LLP

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OF OTOLARYNGOLOGY

SINUS & ALLERGY
FACIAL PLASTIC SURGERY
HEARING & BALANCE DISORDERS
SNORING & SLEEP APNEA
HEAD & NECK SURGERY

MEDICAL HISTORY

Today's Date _____

Birth date (MM/DD/YYYY) _____

Name: _____

Last

First

ALLERGIES NONE YES - PLEASE LIST _____

LIST CURRENT MEDICATIONS (include all non-prescription medications you take) _____

PLEASE CHECK CURRENT/CHRONIC MEDICAL CONDITIONS NONE

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> acid reflux | <input type="checkbox"/> depression | <input type="checkbox"/> high cholesterol | <input type="checkbox"/> thyroid disease |
| <input type="checkbox"/> anemia | <input type="checkbox"/> emphysema | <input type="checkbox"/> HIV | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> gallbladder | <input type="checkbox"/> irregular heart beat | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> glaucoma | <input type="checkbox"/> kidney | |
| <input type="checkbox"/> asthma/allergies | <input type="checkbox"/> gynecologic dis. | <input type="checkbox"/> migraine | |
| <input type="checkbox"/> bleeding/clotting disease | <input type="checkbox"/> lupus | <input type="checkbox"/> parathyroid disease | |
| <input type="checkbox"/> breast disease | <input type="checkbox"/> headaches | <input type="checkbox"/> pneumonia | |
| <input type="checkbox"/> bronchitis | <input type="checkbox"/> heart attack date _____ | <input type="checkbox"/> rheumatoid arthritis | |
| <input type="checkbox"/> cancer of _____ | <input type="checkbox"/> heart disease | <input type="checkbox"/> sarcoidosis | |
| <input type="checkbox"/> chronic lung disease | <input type="checkbox"/> hepatitis B | <input type="checkbox"/> seizures/epilepsy | |
| <input type="checkbox"/> COPD | <input type="checkbox"/> hepatitis C | <input type="checkbox"/> skin condition (eczema/psoriasis) | |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> stroke date _____ | |

OTHER MEDICAL CONDITIONS: _____

SURGERIES (DESCRIBE TYPE & YEAR) _____

Tobacco Usage: NO YES. If yes: PACKS PER DAY _____

Alcohol Use: NO Yes. If Yes, Occasional Weekly Daily

Patient Signature _____