Oakdale ear, nose & throat Clinic

# 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.***

Patient Name: _____ Date of Birth: _____

If a minor, Parent/Guardian Name(s): _____

❑ Male ❑ Female Height: _____ Weight: _____ Preferred Language: _____

Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ White
❑ Native Hawaiian or other Pacific Islander ❑ Unspecified/Other ❑ Declined to Specify

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unspecified ❑ Declined to Specify

Primary Care Physician: _____ Referring Physician: _____

Pharmacy: _____ Location: _____ Phone: _____

To respect your privacy, how can we reach you regarding your health information, lab test results, medication, or billing? Preferred Phone: _____ May we leave a message? ❑ Yes ❑ No

**REASON FOR TODAY'S VISIT**: _____

_____

**HOW LONG HAVE YOU HAD THIS PROBLEM**? _____

**WHAT TREATMENT(S) HAVE YOU RECEIVED?** _____

**WHAT TESTS HAVE BEEN PERFORMED?** _____

**PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:** ❑ **SEE ATTACHED LIST**

*(Include aspirin, ibuprofen, vitamins, fish oil, over-the-counter medications, etc.)*

| Name of Medication | Dosage | Name of Medication | Dosage |
|---|---|---|---|
| 1. | | 5. | |
| 2. | | 6. | |
| 3. | | 7. | |
| 4. | | 8. | |

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

| Name of Medication/Reaction | Name of Medication/Reaction |
|---|---|
| 1. | 5. |
| 2. | 6. |
| 3. | 7. |
| 4. | 8. |

**SURGICAL HISTORY**: *(If you completed the online survey, skip this section.)*

| Type of Surgery/Procedure and Year it Occurred | Type of Surgery/Procedure and Year it Occurred |
|---|---|
| 1. | 5. |
| 2. | 6. |
| 3. | 7. |
| 4. | 8. |

Signature: _____ Date: _____