VERNOSE MCGRATH
ASLANIDIS

PATIENT MEDICAL HISTORY

PatientName:_____**DateOfBirth**:____/____/_____ **Date**:____/____/_____

Height:_____feet_____inches **Weight**:_____lbs

Pharmacy:_____Street_____City_____Zip_____

Known Drug Allergies

NONE

_____

_____

Use of Alcohol:
YES NO HOW MUCH: _____
Use of Drugs:
YES NO RECOVERING
Use of Caffeine:
YES NO
HOW MANY OUNCES / DAY: _____

MEDICATIONS

NAME	DOSE
NONE	

Smoking Histroy

Yes **NO** **QUIT**: When_____

Packs/Day_____**How Long**:_____

Do you chew tobacco? YES NO

Exposed to 2nd hand smoke? YES NO

Occupation: _____

MEDICAL HISTORY

(CIRCLE)

DIABETES HIGH BLOOD PRESSURE
ASTHMA COPD
GERD SLEEP APNEA
HEART ATTACK

_____
_____
_____

SURGICAL HISTORY

NONE

_____
_____
_____
_____

I certify that the information provided is correct to the best of my knowledge. I will not hold my doctor or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form or because of my failure to follow through with necessary diagnostic testing, prescribed treatment or procedures, or follow up of scheduled appointments. I certify that it is my responsibility to carry out my doctor's orders as they pertain to my condition.

PATIENT SIGNATURE:_____DATE:____/____/_____

PHYSICIAN SIGNATURE:_____DATE:____/____/_____

VERNOSE MCGRATH
ASLANIDIS

PATIENT HISTORY

NAME:_____

DATE: _____

WHAT IS THE REASON FOR YOUR VISIT? (CHIEF COMPLAINT AND SPECIFIC SYMPTOMS):

_____

_____

_____

_____

WHEN DID PROBLEM BEGIN? (DAYS/MONTHS/YEARS):_____

WHAT TREATMENT HAVE YOU RECEIVED? _____

WHAT TESTS HAVE BEEN PERFOMED? _____

_____

HAVE YOU SEEN ANOTHER E.N.T.? YES or NO

IS THIS VISIT FOR A SECOND OPINION? YES or NO

NOTES:

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PATIENT SIGNATURE: _____DATE:____/____/_____

PHYSICIAN SIGNATURE: _____DATE:____/____/_____