

**HUDSON VALLEY OTOLARYNGOLOGY
PERSONAL MEDICAL HISTORY FORM**

NAME: _____ DATE: ____/____/____

Medical History:

Do you have a Primary Medical Doctor or Referring Doctor? No Yes If, Yes,

Name of Doctor and Practice: _____

Address: _____ Phone #: _____

List Operations (include date): None Yes:

Are you presently taking any medications? No Yes If Yes, Name(s):

Are you allergic to any medications? No Yes If Yes, Name(s):

Are you allergic to any other agents? (bees, pollen, etc.) No Yes If Yes, Name(s):

Have you ever been treated for: (PLEASE CIRCLE)

Heart Disease
Heart Murmur
Rheumatic Fever
High Blood Pressure

Asthma
Cough
Epilepsy (Seizures)
Hepatitis

Hearing Loss
Sinusitis
Anemia
Thyroid

Disorder

Diabetes
Stroke
Lung Disease
Tuberculosis

Jaundice
Arthritis
Kidney Stones
Cancer: Type(s): _____

Hyperparathyroidism
Hay Fever
Glaucoma
Sleep Apnea

Social History: (Complete either for Adult or Child)

Adult Patients:

Marital Status: Single Married Divorced Widowed Occupation: _____

Do you use alcohol? Never Rarely Occasionally Daily Approximate Amount:

Do you smoke? Never Quit (Date: ___/___/___), Yes

Approximate Amount: ___ packs / day / wk / month Number of years you have smoked: _____

Do you chew tobacco? No Yes Quit (Date: ___/___/___)

Do you drink caffeinated beverages? No Yes Amount: _____ cups / day / week coffee / tea / soda

Is your Sodium intake (Salt): High Average Low

Do you have pets? No Yes (List):

Children:

Daycare? No Yes School Grade: _____ Exposure to Second Hand Smoke No Yes

Do you have pets? No Yes (List): _____

Breast Fed? No Yes How many months? _____ Immunizations Up to Date? No Yes

*****OVER PLEASE*****

Family History:

Have any of your blood relatives had any of the following illnesses?
(grandparents, aunts, uncles, parents, brothers, sisters etc.) PLEASE CIRCLE

- | | |
|----------------------|-----------------|
| Diabetes | Tuberculosis |
| Cancer | Hearing Loss |
| Bleeding Disorder | Dizziness |
| Glaucoma | Heart Disease |
| Epilepsy | Thyroid Disease |
| High Blood Pressure | |
| Others (Name): _____ | |

Please give the following information about your immediate family:

<u>Relationship</u>	<u>Age if Living</u>	<u>Age at Death</u>	<u>State of Health or Cause of Death</u>
Father	_____	_____	

Mother

Brother(s)

Sister(s)

Signature: _____

Date: ____/____/____