WELLSTAR Medical Group

Ear, Nose & Throat

Name:_____ DOB:____/____/____

Surgical History (Please "X" the conditions that apply)

Adenoidectomy		Cosmetic Surgery		Sinus Surgery	
Brain Surgery		Ear Tubes		Thyroid Surgery	
Breast Surgery		Eye Surgery		Tonsillectomy	
Bronchoscopy		Parathyroid Surgery			

Please List any other surgeries you have had:_____

_____

_____

Family History (Please "X" the conditions that apply)

	Mother	Father	Sister	Brother	*MGM	*MGF	*PGM	*PGF
Allergies								
Asthma								
Autoimmune								
Cancer								
Cholesterol								
Cleft Lip								
Cleft Palate								
Coronary								
Depression								
Developmental								
Diabetes								
Ear Infections								
GERD								
Hearing Loss								
Hypertension								
Kidney Disease								
Migraines								
Obesity								
Seizures								
Sleep Apnea								
Sickle Cell Anemia								
Thyroid Disease								

***Maternal Grandmother/ Grandfather and Paternal Grandmother/ Grandfather**

Please List any significant family history or bleeding disorders that are not included above:

_____

_____

_____

_____

WELLSTAR Medical Group

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Today's Date:___/___/_____

Name:_____ DOB:___/____/_____ Sex: Male or Female

Primary Care Physician:_____ Referring Physician:_____

Briefly describe the main reason for your appointment today:_____

_____

Do you currently use tobacco products? YES NO **If YES, what type: Cigarettes Cigars Smokeless**	Have you ever smoked? YES NO **If Yes, when did you start?**_____ **When did you stop?**
Do you drink alcohol? YES NO **If YES, how much and how often?**_____	Current weight:_____ Current height: _____

Do you have any allergies: Please circle and list any others not listed

Penicillin	Morphine	Demerol	Cephalosporins	Clindamycin	IV Dye/ Iodine
Sulfa	Codeine	Latex	Tape/ Adhesive	Erythromycin	Shellfish
OTHER:					

Do you take any of the following medications? (Please "X" by the medications)

Aspirin/ BC Powder		Ibuprofen/Motrin/Advil		Gingko Biloba	
Coumadin		Plavix		Vitamin E	

Please list ALL other medications you are currently taking: (attach additional sheet if needed)

Name of medication	Dose	Name of medication	Dose
1._____		6._____	
2._____		7._____	
3._____		8._____	
4._____		9._____	
5._____		10._____	

What pharmacy do you use? (Please give name, phone number and address)_____

_____

Medical History (Please "X" the conditions that apply)

Anemia		COPD		GERD/Reflux		High Cholesterol		Seizures	
Anxiety		Coronary Artery Disease		Graves Disease		Hypertension		Sleep Apnea	
Arthritis		Depression		Headaches		Hyperthyroidism		Tinnitus	
Asthma		Diabetes		Heart Failure		Kidney disorder		Ulcers	
Cancer		Emphysema		Heart Murmur		Migraine			

Please list any other conditions not listed:_____

_____