Ear, Nose & Throat
SPECIALISTS OF ILLINOIS

Pediatric
Ear, Nose & Throat
SPECIALISTS OF ILLINOIS

PATIENT MEDICAL HISTORY FORM

Patient Name: _____ Today's Date: _____ /_____ /_____

Please list the name(s) of your doctor(s):

Physician Name: _____ Physician Name: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

Have you ever had an audiogram (hearing test)? ☐ YES ☐ NO

If you wear a HEARING AID, where did you purchase it/them? _____

List all allergies to medications:

_____

_____

List all medications you take, including over-the-counter medications, vitamins or herbal supplements:

_____

_____

_____

_____

_____

Height: _____ **Weight:** _____

Do you smoke? ☐ YES ☐ NO

If yes, how much and for how many years? _____

Do you drink? ☐ YES ☐ NO

If yes, how much and for how many years? _____

Do you use marijuana or other drugs? ☐ YES ☐ NO

Do you have the following illnesses?

Diabetes	☐	Dementia/Alzheimer's	☐	AIDS/HIV	☐
Bleeding Disorders	☐	Stroke	☐	HEPATITIS C	☐
Heart Disease	☐	Hearing Loss	☐	Neurologic Problems	☐
Anesthesia Problems	☐	Thyroid	☐	Immune Deficiency	☐
High Blood Pressure	☐	Cancer	☐	Transplant Surgery	☐
Kidney Disease	☐	Type of Cancer: _____		Others: _____	
Lung/Asthma	☐	OCA/CPAP	☐		

Surgeries: _____

_____

_____

_____

Hospitalization: _____

_____