

BEACHES EAR, NOSE AND THROAT, P.A.

History and Physical Examination

Name: _____ Date of Visit _____

Date of Birth: _____ Age: _____

Sex: _____ Height: _____ Weight: _____

Referred by: _____

Primary Care Physician: _____

Chief Complaint: (List and /or describe your reason(s) for this doctor visit)

Medications: (List all meds you are currently taking including drug name and dose)

Allergies: (List all medications to which you are allergic)

Past History:

Adult Medical Illnesses: (List all medical problems that you have currently or have had in the past been treated for by a doctor, including hospital admissions)

Operations:

Accidents and Injuries:

Family History:

If any blood relative has suffered any of the following-Please circle the number and indicate which relative:

- | | | | | |
|----------------|-------------------|-------------------|----------------------|-------|
| 1) Epilepsy | 6) Thyroid | 11) Osteoporosis | 16) High Cholesterol | _____ |
| 2) Migraine | 7) Hay fever | 12) Arthritis | 17) Alcoholism | _____ |
| 3) Mental Ill. | 8) Asthma | 13) Heart Disease | 18) Cancer | _____ |
| 4) Glaucoma | 9) Anemia | 14) Stroke | | _____ |
| 5) Diabetes | 10) Bleeds easily | 15) Hypertension | | _____ |

Social History:

Occupation - _____

Tobacco use- _____

Alcohol use - _____

Illicit drugs - _____

Foreign travel - _____