

Chihal ENT Associates, P.A.
Medical History Form

Patient Name: _____ **Date:** _____

What is your main complaint today? _____

Allergies to Medication _____

Current Medications (include prescription and over the counter medications)

Medical Problems for which you are currently treated or have received treatment in the last 24 months (circle all that apply)

Allergies	Diabetes	Asthma	Reactive Airway Disease
Head Injury	Eczema	Other Skin Disease	Hearing Loss
Thyroid	Lung Problems	Heart Problems	Tinnitus (ringing in ears)
Stomach Problems	Blood Clots	Stroke	Snoring
High Blood Pressure	Latex Allergy	Cancer (type) _____	
Kidney Problems	Liver Problems	Other: _____	

Past Surgeries or Procedures _____

Any history of complications from Anesthesia (please explain)

Tobacco: Yes No If yes, how much? _____, if quit, how long ago? _____

Alcohol: Yes No If yes, how much? _____, if quit, how long ago? _____

Family History (circle all that apply)

Cancer	Excessive Bleeding	Problems with Anesthesia
Diabetes	Hypertension	Heart attack or Stroke at Young Age
Seizures	Mental Illness	Other: _____