ENT Centers of excellence

Today's Date: ____/____/_____

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. PLEASE FILL OUT EVERY ITEM. It is important for your doctor to know you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

PATIENTS FULL NAME: _____

SEX: ___M ___F RACE: _____ ETHNICITY: _____ DOB: _____

PREFERRED LANGUAGE: _____ PRIMARY CARE PHYSICIAN: _____

PHARMACY PREFERENCE: _____

REASON FOR TODAY'S VISIT: _____

PLEASE LIST MEDICATIONS YOU ARE CURRENTLY TAKING:

ARE YOU ALLERGIC TO ANY MEDICATION? ____YES ___ NO. IF SO LIST BELOW:

AUTHORIZATION FOR MEDICAL CARE AND TREATMENT: I recognize that a condition exists requires medical care and I voluntarily consent to such medical care and treatment, diagnostic procedure by ENT Centers of Excellence as deemed necessary.

I hereby authorize my physician, as a provider by law to furnish medical treatment, diagnostic, x-ray diagnosis or therapy as he/she considers necessary and proper in the treatment of the patient.

_____

SIGNATURE PATIENT/PARENT/GUARDIAN DATE WITNESS SIGNATURE DATE