WCCHS
Wyoming County Community Health System

Otolaryngology Medical History

Patient Name: _____ Date of Birth: _____

Primary Care Provider: _____ Referring Provider: _____

Reason for Today's Visit: _____

What treatment have you received for this condition? _____

_____

Pharmacy/Address: _____/_____

Have you ever had: **Circle Answer**

- High Blood Pressure .....YES .....NO
- Heart Trouble .....YES .....NO
- Epilepsy or Seizures.....YES .....NO
- Excessive Bleeding or Bleeding Tendencies .....YES .....NO
- Diabetes.....YES .....NO
- Liver Disease, Hepatitis or Jaundice.....YES .....NO
- Kidney Disease .....YES .....NO
- Asthma or Chronic Lung Disease .....YES .....NO
- Stomach Ulcers .....YES .....NO
- Cancer/Type_____ .....YES .....NO
- Serious Head Injury .....YES .....NO

- Are you allergic to any medication? .....YES .....NO
  If yes, please list them here _____

  _____
- Are you taking any medications (prescription, over the counter, herbal)? .....YES .....NO

  If yes, please list them here with dosage_____

  _____
- Have you had your Flu Shot this year?.....YES .....NO
- Are you allergic to latex?.....YES .....NO
- Are you pregnant?.....YES .....NO
- Have you had a Mammogram this year? .....YES .....NO
- Do you smoke? .....YES .....NO

  If yes, how much?_____ If yes, how long?_____
- Have you ever smoked?.....YES .....NO
- Smoke free home?.....YES .....NO
- Do you drink alcohol?.....YES .....NO

  If yes, how much?_____ If yes, how often?_____

(PLEASE COMPLETE REVERSE SIDE)

- Have you ever had surgery?.....YES.....NO
  If yes, please list surgeries and dates here:_____
  _____
- Have you ever been hospitalized for a non-surgical condition?.....YES.....NO
  If yes, please give reasons and dates here:_____
  _____

Are you currently experiencing any of the following conditions?

	Circle Answer			Circle Answer	
Fevers	YES	NO	Heartburn	YES	NO
Chills	YES	NO	Watery, Itchy eyes	YES	NO
Blurry vision	YES	NO	Eye pain	YES	NO
Double vision	YES	NO	Ringing in the ears	YES	NO
Hearing loss	YES	NO	Ear pain	YES	NO
Dizziness	YES	NO	Stuffy nose	YES	NO
Runny nose	YES	NO	Sinus pain	YES	NO
Bloody nose	YES	NO	Dry mouth	YES	NO
Snoring	YES	NO	Hoarse voice	YES	NO
Sore throat	YES	NO	Shortness of breath	YES	NO
Cough	YES	NO	Gland swelling	YES	NO
Sneezing	YES	NO			

Does anyone in your family have: (PLEASE LIST FAMILY MEMBER)

Hearing Loss	YES	_____	NO
Heart Disease	YES	_____	NO
High Blood Pressure	YES	_____	NO
Cancers	YES	_____	NO
Diabetes	YES	_____	NO
Problems with Anesthesia	YES	_____	NO

Your Current Height:_____ Your Current Weight:_____

Occupation:_____

If retired, former Occupation:_____

Any other information you would like us to know?_____

_____

_____

Patient Signature:_____Date:_____