Michigan Otolaryngology Surgery Associates

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 information will be entered into your patient file for your doctor to know and consider as he cares for your health needs.

Your Full Name: _____ Birth Date: _____

Primary Care/Family Physician Name: _____

Address: _____

Phone #: _____

Pharmacy Name and Address_____

Who referred you to our office? _____

Do you want a summary of your visit to be sent to your Primary Care/Family physician? _____

What is **the main reason** you are here to see our physician today? _____

_____

What **part of your body (location)** are you having difficulty with and circle your symptoms:

Ears: Wax Pain Dizziness Drainage Decreased Hearing Ringing

Nose: Congestion Drainage Deviated Septum Sinus

Mouth/Throat: Sore Throat Sore or Ulcer in mouth/throat Hoarseness Tonsils

Head: Headache

Neck: Mass or Lump Thyroid

Other: _____

What is the **severity** of your problem: Mild, Moderate, Severe

For **how long** have you been experiencing this problem?

_____ Hours, _____ Days, _____ Months, _____Years

If your problem is an injury, when did the injury occur? _____

Is your problem is an injury is it a work/employment related injury? Yes No

Are you taking any medications now, if yes list all medications below (prescribed, over the counter or herbal medications.

Name of Medication	Dosage (mg)	How Often Do You Take It

ARE YOU ALLERGIC TO ANY MEDICATIONS? If yes list below

Name of Medication	What Type of Reaction Do You Have

List any surgeries or procedures you have had and when you had them.

Type of Surgery or Procedure	Date

Signature: _____ Date: _____

Office use only:

Blood Pressure: _____ Weight: _____ Height: _____