BLUE RIDGE
EAR, NOSE, THROAT
& PLASTIC SURGERY

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Patient History Questionnaire

DATE:_____

NAME: _____ D.O.B. _____ AGE: _____

PRIMARY CARE PHYSICIAN: _____

MAY WE SEND YOUR CLINICAL SUMMARY FOR THIS VISIT TO YOUR PRIMARY CARE PHYSICIAN? ❑YES ❑NO

Pharmacy Information for Prescription Refills : _____

MEDICAL HISTORY: Please check box if you have any of the following medical problems

❑ Arthritis ❑ Asthma ❑ Bleeding Problems ❑Cancer ❑ Cholesterol Problems ❑ADHD ❑Reflux

❑ C.O.P.D. ❑ Diabetes ❑ Heart Trouble ❑ Hepatitis What Type:_____ ❑ High Blood Pressure ❑ HIV/AIDS ❑ Stroke

❑ MRSA ❑ Eye Diseases ❑ Thyroid Problems What Type:_____ ❑ Obstructive Sleep Apnea ❑ Mental Health Problems

❑ Other Medical Problems not listed : _____ What Type:_____

Have you or a family member ever experienced a problem with anesthesia ?

❑NO ❑YES - please describe:_____

Allergies: Drug, Latex, Food, Adhesive Tape, Betadine - Iodine, Etc.

1._____ 3. _____

2._____ 4. _____

Family History:

Do your parents or siblings have any health problems ? ❑ No ❑ Yes, please describe below

_____

_____

_____

Social History:

Alcohol Use: ❑ Never ❑ Rarely ❑ Moderate ❑ Daily/How much? _____

Illegal Drug Use: ❑ Never Type and Frequency?_____

Tobacco Use: ❑ Never ❑ Current Smoker / Packs per day ?_____

❑ Quit/when?_____ How many years did you use tobacco products?_____

Occupation: _____

Current Medications: Include aspirin, vitamins, diet pills, birth control pills, herbs, etc.

MEDICATION	DOSAGE	MEDICATION	DOSAGE
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	