Thomas Jefferson University | Jefferson Medical College | Jefferson University Physicians

Department of Otolaryngology
Head and Neck Surgery

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PATIENT HEALTH HISTORY

Please provide the following confidential information regarding your medical history. Thank you.

Name:_____ Age:_____

Reason for Your Appointment:_____

_____

_____

Who Referred You?_____

Please answer the following questions about your medical history.

	NO	YES	
Do you take any medicines?			List:_____
Are you allergic to any medicines?			List:_____
Do you smoke or chew tobacco?			How much per day?_____ How many years?
Do you drink alcohol?			How much?_____ How often?
Do you take aspirin?			How much?_____ How often?
Do you bleed or bruise easily?			
Have you had any previous surgery?			List:_____
Are you pregnant?			
Are there any illnesses that run in the family?			List:_____

PLEASE FILL OUT OPPOSITE SIDE. THANK YOU.

PATIENT HEALTH HISTORY

Do you have any of the following medical problems? If yes, please explain.

	NO	YES	
Heart disease			
High blood pressure			
Diabetes			
Thyroid problems			
High cholesterol			
Rheumatic fever			
Heart murmurs			
Stomach problems			
Liver problems or hepatitis			
Respiratory problems			
Arthritis			
Seizures or epilepsy			
Blood disorders			
Cancer			
Other			

What is your present occupation?_____

What occupations have you had?_____

_____

Do you have any of the following symptoms now? (please check those that apply)

Fever	_____	Shortness of breath	_____
Weight loss	_____	Chest pain	_____
Fatigue	_____	Abdominal pain	_____
Visual disturbance	_____	Pain on urination	_____
Hearing loss	_____	Muscle or joint pain	_____
Nasal congestion	_____	Rash	_____
Sore throat	_____	Weakness	_____
Hoarseness	_____	Numbness	_____
Cough	_____	Seasonal allergies	_____

I certify that the above information is complete and accurate.

Patient's Signature_____ Date_____

I certify that I have reviewed the above information with the patient.

Physician's Signature_____ Date_____