OHIO VALLEY
EAR, NOSE & THROAT

Medical History

Patient Name: ____________________

DOB: ____________________ Height (inches): ____________________ Weight (lbs.): ____________________

Reason for Visit: ____________________

Do you have, have you ever had or are you treated for any of the following (If you check yes, please explain):

- ☐ Seasonal Allergies
- ☐ Skin Disorders
- ☐ Asthma
- ☐ Sleep Apnea
- ☐ Bleeding Disorder
- ☐ Anemia
- ☐ Blood Clots
- ☐ Auto Immune Disorder
- ☐ High Blood Pressure
- ☐ Heart Condition
- ☐ Stroke/TIA
- ☐ Pacemaker
- ☐ Hearing Loss
- ☐ Migraine Headaches
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Bladder Disease
- ☐ Seizure Disorder
- ☐ COPD/Emphysema/Chronic Bronchitis
- ☐ Cancer (Type and/or Location)? ____________________
- ☐ Do You Have a Cardiologist? Who? ____________________
- ☐ Devices or Metal in Body? ____________________

FAMILY HISTORY:

Does anyone in your family (parents, siblings, children) have the following? If yes, list family member(s)/description:

Y N Diabetes ____________________

Y N High Blood Pressure ____________________

Y N Heart Disease ____________________

Y N High Cholesterol ____________________

Y N Cancer ____________________

Y N Mental Illness ____________________

Y N Bleeding Disorder ____________________

Y N Stroke ____________________

Y N Asthma ____________________

Y N Allergies ____________________

Y N Hay Fever ____________________

SOCIAL HISTORY:

Do you smoke? ☐ Never ☐ Current ☐ Previous

If applicable: When did you start? ____________ When did you quit? ____________ How many do you smoke per day? ____________

Smokeless tobacco? ☐ Never ☐ Current ☐ Previous

If applicable: When did you start? ____________ When did you quit? ____________

Did you have a drink containing alcohol in the last year? Yes No

If yes: How often? Monthly or less ______ 2-4/month ______ 3-4/month ______ 5-6/month ______ 7-9/month ______ 10 or more ______

Do you drink Caffeine? ☐ Never ☐ Yes

If yes: How many cups of coffee, tea, caffeinated soda or carbonated beverages per day? ____________

Do you have a history of drug abuse? ☐ Never ☐ Current ☐ Previous

Reviewed by: ____________________ **Date:** ____________________

Ear, Nose & Throat

435 South Burnett Road, Springfield, OH. 45505
p: **937-325-8796** | f: **877-370-4708** | **ohiovalleyent**.com

OHIO VALLEY
EAR, NOSE & THROAT

PLEASE LIST ALL PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS YOU ARE TAKING:

MEDICATION	DOSAGE

PLEASE LIST ALL MEDICATIONS YOU ARE ALLERGIC TO AND YOUR REACTION TO THE MEDICATION:

PLEASE LIST ALL OF YOUR PAST SURGERIES

01/24

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