Coastal Carolina Otolaryngology Associates, P.A.

Patient Medical History Questionnaire

Print Name: _____ **Date:** _____

Medical History: Please list all illnesses. (i.e., cancer, diabetes. high blood pressure, stroke, heart attack, etc.)

1._____ 2. _____ 3._____
4._____ 5. _____ 6._____
7._____ 8. _____ 9._____

Surgical History: Please list all of the surgeries that you have had and the approximate date performed.

1._____ 2. _____ 3._____
4._____ 5. _____ 6._____
7._____ 8. _____ 9._____

Family History: Please list all illnesses that run in your immediate family. List maternal or paternal including grandparents.

1._____ 2. _____ 3._____
4._____ 5. _____ 6._____
7._____ 8. _____ 9._____

Social History:

Do you currently smoke or use tobacco products? _____ If yes, age started _____, how much per day? _____

If you are a former smoker, what age did you start and stop? _____ / _____

Do you drink alcoholic beverages? _____ How much in an average week? _____

How many caffeinated beverages do you consume daily? _____

Allergies: Please list all allergies (both to medications and environmental allergens) that you have.

1._____ 2. _____ 3._____
4._____ 5. _____ 6._____

Current Medications: Please list all current medications and their dosages if known or allow us to copy your list.
*** INCLUDE OVER THE COUNTER MEDICATIONS**

1._____ 2. _____ 3._____
4._____ 5. _____ 6._____
7._____ 8. _____ 9._____
10. _____ 11. _____ 12. _____

Is there a possibility that you may be pregnant? ☐ **Yes** ☐ **No**

Have you had/or have Hepatitis? ☐ **Yes** ☐ **No**

Have you had/or have HIV? ☐ **Yes** ☐ **No**

PLEASE COMPLETE BACK SIDE OF FORM.