ENT Consultants of North MS

Date: ______________________________ **Age:**__________

Name: ____

Briefly state why you are being seen today (Chief Complain)

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Past Medical History:

Check (x) any current or past medical problems:

__Pacemaker
__Heart Trouble or murmur
__Nasal Allergies/Hay fever
__High Blood Pressure
__Mental Health Problems
__Heart Valve Replacement
__Stomach/Duodenal Ulcers
__Sexually Transmitted Disease
__Organ Transplant Recipient
__Joint Replacement
__Tuberculosis
__Anything Else(explain):
__On Dialysis
__Stroke
__Bleeding Disorders
__Tumor/Cancer
__Diabetes
__Seizures
__Kidney Problems
__Sickle Cell Disease/Trait
__Asthma/Lung Disease
__Arthritis
__Glaucoma
__Hepatitis/Liver Disease
__Thyroid Disease

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Preventive Screenings:

Flu Vaccine **Yes** **No**
If Yes, Date __________________
Pneumonia Vaccine **Yes** **No**
If Yes, Date __________________
***Mammogram** **Yes** **No**
If Yes, Data __________________
Test Ordered By __________________
***Colonoscopy** **Yes** **No**
Test Ordered By __________________
Recent Falls **Yes** **No**
Depression **Yes** **No**

Past Surgical History:

List all previous **operations** including year performed:

____

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Are you **allergic** to any medications? YES NO

If YES, please list the medication(s) and your reaction to them(rash, hives, breathing problems):

____

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List all current **medications** including vitamins and herbal supplements:

****If you have a list of your medication we can make a copy and attach to this sheet!****

Medication Name	Dose	Reason for Taking
____________	________	________________
____________	________	________________
____________	________	________________
____________	________	________________
____________	________	________________