

Buffalo Otolaryngology Group, P.C.

Name: _____

Date: _____

What ear, nose or throat problem brings you to our office today? _____

Medication Allergies: _____

Other Allergies: _____

Prescription Medicines you are Currently Taking:

Medicine Name	Dose	How often taken

Vitamins/Over-the-Counter Medicines you are Currently Taking: _____

Pharmacy Information:

Pharmacy Name: _____

Address: _____

Phone #: _____

Past Surgeries:

Social History:

Do you use tobacco? YES NO

Packs per day: _____ # of years: _____

Do you use alcohol? YES NO

Ht: _____ Wt: _____

History Form Updated 09/07/11

Present or Past Medical Conditions:

Diabetes YES NO

Cancer YES NO

If yes, where _____

Kidneys YES NO

Bruising Easily/Excessively YES NO

Sleep Apnea YES NO

Bladder YES NO

Thyroid YES NO

Stomach YES NO

Intestinal YES NO

Bleeding Disorders YES NO

Blood Problems YES NO

Liver Problems YES NO

Hepatitis YES NO

Vision YES NO

Stroke YES NO

Heart YES NO

High Blood Pressure YES NO

Mitral Valve Prolapse YES NO

Lung Problems YES NO

Asthma/Bronchitis YES NO

Migraine YES NO

Neurologic Problems YES NO

Any Medical Condition Not Mentioned

Above? YES NO

If so Explain? _____

Is there any reason why you cannot accept a

blood transfusion? YES NO

Family History:

Hearing Loss YES NO

Ear Surgery YES NO

Allergies YES NO

Bleeding Problems YES NO

Anesthesia Problems YES NO

I have read the above questions and have completed them truthfully and to the best of my ability.

Signature of Patient/Parent/Guardian

Date

Witness

<u>For Office Use Only:</u>	
<u>Updated Histories</u>	