

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:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

Past Surgeries:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Social History:**

Do you use tobacco? YES NO

Packs per day: \_\_\_\_\_ # of years: \_\_\_\_\_

Do you use alcohol? YES NO

Ht: \_\_\_\_\_ Wt: \_\_\_\_\_

**Present or Past Medical Conditions:**

Diabetes YES NO

Cancer YES NO

If yes, where \_\_\_\_\_

Migraines YES NO

Neurologic Problems YES NO

**Present or Past Medical Conditions:**

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? \_\_\_\_\_

**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

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