MIDWEST EAR, NOSE & THROAT SPECIALISTS, P.C.
PATIENT HISTORY FORM

TODAY'S DATE: _____

PATIENT NAME:_____ **SS#**:_____-_____-_____

PATIENT BIRTHDATE:_____ **SEX**: M F **HEIGHT**:_____ **WEIGHT**: _____

PATIENT ADDRESS:_____City:_____ State:_____ Zip:_____

PHONE #: Home:_____ Cell: _____ Work: _____

PARENTS/RESPONSIBLE PARTY (if minor):_____

PARENTS/RESPONSIBLE PARTY PLACE OF WORK:_____

NAME OF SPOUSE (if married):_____**PHARMACY**: _____

REFERRING PHYSICIAN: *Name & Address:*_____

FAMILY PHYSICIAN: *Name & Address:*_____

REASON FOR APPOINTMENT TODAY*:*_____

MEDICATION ALLERGIES *AND* **REACTIONS***:*_____

HEALTH PROBLEMS: _____

_____

PAST SURGERY AND DATE:_____

_____

_____

_____

MEDICATIONS AND DOSAGE (include vitamins and herbal supplements) *OR* a **COPY OF MEDICATIONS**

MEDICATION NAME	DOSE

MEDICATION NAME	DOSE

Currently on: Aspirin/Ibuprofen/blood thinner? YES NO **Females**: Are you pregnant now? YES NO
Do you require antibiotics prior to surgery or dental cleaning (due to heart condition/joint replacement)? YES NO
Family History: have you or anyone in your family had:
-Anesthesia problems? YES NO *if yes please explain further*:_____

-Bleeding problems? YES NO *if yes please explain further*: _____

-OVER-

MIDWEST EAR, NOSE & THROAT SPECIALISTS, P.C.

INSURANCE INFORMATION REQUIRED

Card Holder *(NAME on insurance card):*_____ **Date of Birth**:_____

Name of Employer:_____ **SS#:** _____-_____-_____

PRIVACY/PERMISSION TO RELEASE HEALTH INFORMATION

DO WE HAVE YOUR PERMISSION TO:

-LEAVE A MESSAGE ON YOU ANSWERING MACHINE AT **HOME** NUMBER?: YES NO

-LEAVE A MESSAGE ON YOU ANSWERING MACHINE ON **CELL** PHONE?: YES NO

PLEASE LIST ANYONE WITH WHOM YOU GIVE **MIDWEST ENT** PERMISSION TO DISCUSS YOUR HEALTH INFORMATION WITH:

NAME	PHONE NUMBER	RELATIONSHIP TO PATIENT

_____ _____ _____

SIGNATURE OF PATIENT OR PARENT WITNESS DATE SIGNED