MEDICAL HISTORY

NAME: _____ DATE: _____

HAVE YOU EVER HAD:

YES	NO		YES	NO	
_____	_____	HEART DISEASE	_____	_____	HEART MURMUR
_____	_____	HIGH BLOOD PRESSURE	_____	_____	COUGHING UP BLOOD
_____	_____	STROKE	_____	_____	CHRONIC LUNG CONDITION
_____	_____	KIDNEY DISEASE	_____	_____	ASTHMA
_____	_____	TUBERCULOSIS	_____	_____	THYROID TROUBLE
_____	_____	CANCER	_____	_____	UNCONSCIOUSNESS FOR ANY REASON
_____	_____	LIVER DISEASE			
_____	_____	JAUNDICE / HEPATITIS	_____	_____	SEVERE HEAD INJURY
_____	_____	ANEMIA / BLOOD DISEASE	_____	_____	STOMACH TROUBLE / ULCER
_____	_____	SYPHILIS	_____	_____	DIABETES
_____	_____	HIV			

DO YOU HAVE OR ARE YOU CURRENLTY HAVING TROUBLE WITH ANY OF THE FOLLOWING:

_____	_____	FREQUENT EAR INFECTIONS	_____	_____	HOLE IN EITHER EARDRUM
_____	_____	FREQUENT RESPIRATORY INFECTIONS	_____	_____	DRAINING FROM EITHER EAR
_____	_____	FREQUENT SINUS TROUBLE	_____	_____	PERSISTENT HOARSENESS
_____	_____	DIZZY SPELLS OR FAINTING	_____	_____	LUMPS OR SWELLING IN NECK
_____	_____	DIFFICULTY IN HEARING	_____	_____	DIFFICULTY IN SWALLOWING
_____	_____	RINGING OR NOISE IN THE EARS			

WHAT IS YOUR CHIEF COMPLAINT TODAY?_____

_____

DO YOU HAVE ANY DRUG ALLERGIES? YES NO
IF YES, LIST BELOW.

_____

DO YOU HAVE ANY ALLERGIES OTHER THAN TO MEDICATION? YES NO
IF YES, LIST BELOW.

_____

ARE YOU CURRENTLY TAKING ANY MEDICATION? YES NO
IF YES, LIST BELOW.

_____

HAVE YOU HAD ANY PREVIOUS SURGERY? YES NO
IF YES, LIST BELOW:

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