PDX ENT & AUDIOLOGY MEDICAL GROUP

Patient Medical History

Your Name: _____ Date of Birth: _____

How were you referred to this office? _____

Referring Provider (or your Primary Care Provider): _____

Preferred Pharmacy: _____

Reason for today's visit: _____

Past Medical History: check ALL that apply ☑ including past and current diagnoses		
☐ High Blood Pressure	☐ Heart Attack (MI) Date(s): _____	☐ Stroke
☐ Atrial Fibrillation	☐ Coronary Artery Disease	☐ Kidney Failure
☐ Asthma	☐ Bleeding Disorder	☐ DVT
☐ Sleep Apnea	☐ COPD/chronic bronchitis	☐ HIV
☐ Acid Reflux	☐ Diabetes Most recent HbA1C: _____	☐ Hepatitis B or C
☐ Cancer (please write in type/ location): ☐ Chemotherapy ☐ Radiation treatment	☐ Other medical problems not listed above:	

Past Surgeries: check ALL that apply ☑ and please include the year surgery was performed					
	Year		Year		Year
☐ Ear tubes		☐ Tympanoplasty		☐ Mastoidectomy	
☐ Septoplasty		☐ Rhinoplasty		☐ Sinus surgery	
☐ Tonsillectomy		☐ Adenoidectomy		☐ Thyroidectomy	
☐ Cardiac Stents		☐ Cardiac Bypass		☐ Gastric bypass or banding	
☐ Skin Cancer		☐ Kidney Transplant			
☐ Other surgery not listed above:					

Family Medical History: check ALL that apply ☑			
	Family Member		Family Member
☐ Asthma		☐ Thyroid cancer	
☐ Hearing loss		☐ Other cancer	
☐ Bleeding Disorder (type: _____)		☐ Heart Attack	
☐ Problems with Anesthesia		☐ Stroke before age 60	

Social History: check ALL that apply ☑			
Tobacco Status:	Alcohol Use:	Employer/Job Title:	Marital Status:

Please list all current medications, including Over-The-Counter. If more space is needed, see third page

MEDICATIONS: _____

_____

_____

_____

MED ALLERGIES: _____

_____

_____

_____