Past Medical History

Name:____________________________________ **Age**:________ **Referred by**:________________________

Chief Complaint: ____

Review of Symptoms: (circle if any of the following apply)

Headaches Fevers Chills Unexplained weight loss Nosebleeds Tinnitus Loss of smell
Hearing loss Trouble swallowing Shortness of breath Hoarseness Tingling Cough blood
Skin rash Easy bruising Heartburn Muscular weakness Numbness Chest Pain
Paralysis Blood in stool or urine

Past History: Surgery – **Have you ever been operated on**? YES NO

Year ________ Surgery ____ Dr. ___________________________
Year ________ Surgery ____ Dr. ___________________________
Year ________ Surgery ____ Dr. ___________________________

Hospitalizations: Have you ever been hospitalized for any other medical problems? YES NO

Year ________ Problem ____
Year ________ Problem ____

Medical Illnesses: Do you have any of the following diseases? (**circle and explain**)

High blood pressure Diabetes Asthma Cancer Hepatitis Migraines Reflux (GERD)
Thyroid disease Tuberculosis HIV Other:

____
____

Bleeding Tendency? YES NO **Have you ever received a blood transfusion**? YES NO

Current Medications: ______________________________ ____________________________________
______________________________ ______________________________ ____________________________________
______________________________ ______________________________ ____________________________________

Drug Allergies? YES NO Penicillin Sulfa Erythromycin Cephalosporin Codeine Morphine Latex
Others: ____

Trauma: **Any head injuries**? YES NO Year____________ **Loss of consciousness**? YES NO

Family History: Age Major Illnesses If deceased, age and cause of death

Father: ____
Mother:____
Brother/Sister____
____
____
Son/Daughter: ____
____
____

Social History: Marital status: ___________ Highest grade completed: High school ____ College ____ Grad School _____

Do you smoke? YES NO If yes, ________ pack per day Year started:_________ Year quit: ____________
Drink alcohol? YES NO If yes, amount ____

Is there anything else you wish Alaska Sinus Center to know about your health or medical history? ____________________
____
____

I give permission for Alaska Sinus Center to examine me or the child for whom I am the legal guardian as would be necessary in the course of my/our treatment.

______________________	____________________________________	______________________
Date	**Signature** (please sign)	**Relationship**