Patient Health History

Ear, Nose & Throat Associates & Watauga Hearing

Today's Date _____

Patient Name _____ **Date of Birth** _____
First Name Middle Initial Last name

What doctor referred you to us today _____ **City & State** _____

Patient's Primary Care Physician _____ **City & State** _____

What Pharmacy & location do you use _____ **City & State** _____

What is the reason for today's visit _____

Please list the perscriptions, medicines, over-the-counter preparations, herbs, vitamins, supplements, etc. you are currently taking:

Name of Medication or supplement	Dosage	How often	Condition being treated

Are you allergic to any medicines:

Medicine	Describe the allergic reaction you had

Please list significant medical problems, surgeries, or hospitalizations the doctor should be made aware:

Have you ever had problems with anesthesia (numbed or put to sleep)? **Yes** **No**