



Patient Health History

In order for us to obtain a complete medical history and better assess you, it is important for you to thoroughly fill out this form. **Please complete every item.** It is important for your doctor to know you have carefully reviewed every area of this form. The information listed will be entered into the computer and you are welcomed to a copy of the report.

Full Name: _____ Date of Birth: _____

Pharmacy: _____ Pharmacy Phone: _____

Current Medications

Are you currently taking ANY kind of medication? (This includes prescription, over-the-counter or herbal medications)

No Yes If yes, please list below and *include dosages*.

Medication Name	Dosage	How Often Taken

Medication Allergies

ARE YOU ALLERGIC TO ANY MEDICATIONS?

No Yes If yes, please list below.

Medication Name	Type of Reaction

What Other Physicians Do You See?

Physician's Name	Phone Number or Location
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Surgeries and Hospitalizations

Have you ever had any problems with anesthesia (being numbed or put to sleep)?

No Yes If **yes**, please list what sort of problems.

Have you ever had ear, nose or throat surgery?

No Yes If **yes**, list surgeries and dates of surgery.

Have you ever had any other surgery ?

No Yes If **yes**, list surgeries and dates of surgery.

Have you ever been hospitalized for a medical problem?

No Yes If **yes**, list hospitalizations, the reason for admission and the date.

Do You Have Sleep Apnea?

- No Yes Nightly snoring interrupted by pauses in breathing?
- No Yes Falling asleep when you shouldn't (i.e. at work, while driving, etc.)?
- No Yes Loss of energy, fatigue?
- No Yes Choking and gasping during sleep?
- No Yes Restless sleep?
- No Yes High blood pressure?
- No Yes Neck size greater than 17" in men, 16" in women?
- No Yes Overweight?
- No Yes Depression?
- No Yes Trouble concentrating?
- No Yes Irritability?
- No Yes Forgetfulness?
- No Yes Morning headaches?
- No Yes Sexual dysfunction?