CARL L FALCONE, MD, PC

Ear, Nose & Throat Clinic
Adult Health History Form

Please print (If you do not understand a question, leave it blank) Provide additional information on a seperate paper to copy.

Patient Name: _____ DOB_____
(Last) (First) (Middle Initial)

Primary Physician: _____Phone#_____

CHRONIC MEDICAL PROBLEMS (examples: high blood pressure, high cholesterol, diabetes, asthma, etc.)

_____

_____

PRIOR SURGERIES WITH DATES_____

_____

_____

BLOOD CONDITIONS: Have you had hepatitis? No ☐ Yes ☐ Have you been tested for HIV? No ☐ Yes ☐

Have you had a blood transfusion? No ☐ Yes ☐ Do you have blood clotting or bruising problems? No ☐ Yes ☐

MEDICATIONS: Prescription medications? (please list)_____

_____

Over the counter medications?_____

ALLERGIES: Are you allergic to any medications?_____

Do you have environmental allergies/hayfever?_____

Do you have food sensitivies?_____

Other allergies?_____

DO YOU SMOKE? No ☐ Yes ☐ How many packs per day for how many hears?_____ If you have quit, when?_____

DO YOU DRINK ALCOHOLIC BEVERAGES? No ☐ Yes ☐ How many drinks per week?_____ or month?_____

FAMILY HISTORY: Mother living: Yes ☐ No ☐ Died of: _____ Father living: Yes ☐ No ☐ Died of:_____

Family history of ear or hearing problems? No ☐ Yes ☐ Family history of allergies? No ☐ Yes ☐

REVIEW OF SYSTEMS: Please check any symptoms you currently have:

General:	Unexplained fevers ☐	Night sweats ☐	Unintentional weight loss ☐	
Skin:	Change in moles ☐	Sore that won't heal ☐		
ENT:	Ear Pain ☐	Drainage ☐	Hearing Loss ☐	Nosebleeds ☐
	Ringing in ears ☐	Sinus problems ☐	Difficulty swallowing ☐	
Cardiovascular:	Chest pain ☐	Irregular heartbeat ☐	Heart murmur ☐	
Respiratory:	Persistent cough ☐	Hoarseness ☐	Shortness of breath ☐	
Gastrointestinal:	Nausea/vomiting ☐	Heartburn ☐	Acid reflux ☐	
Muscle/Joint/Bone:	Pain, weakness or numbness in: Arms ☐	Back ☐	Legs ☐	Neck ☐
Neurologic:	Headache ☐	Numbness ☐	Tingling ☐	
Heme/Lymph:	Enlarged lymph nodes ☐	Excessive bleeding ☐		
Allergy/Immunology:	Decreased immunity ☐	Hay fever ☐		

Signature of the person completing this form: _____***Date***_____

Relationship you have with the Patient: _____***Your Pharmacy:***_____