

Medical and Surgical History

Welcome to Greenwood, Laurens, Abbeville and Newberry Ear, Nose & Throat Centers

Please help us serve you better by completing your medical history before you see the Doctor. Your medical record is strictly confidential.

Name: _____ age: _____ date: _____

Referring Physician: _____ Regular Physician: _____

Location & name of the Pharmacy you use: _____

Reason you are seeing the doctor today? _____

How long have you had this problem? _____

How many times have you been treated for this problem in the past year? _____

What medications or tests have you received for this problem in the past? _____

Past medical history:

List all previous *medical problems*: _____

List all previous *surgeries*: _____

Please list your *daily medications*: (with doses, remember to include lotions, drops, birth control pills, and any recreational drugs) _____

Please list any medications, food, or environmental *allergies*: _____

Social history:

Do you now or did you *smoke tobacco*? _____ packs/day? _____

Do you use *smokeless tobacco*? _____ packs/day? _____

Do you *drink alcohol or beer*? _____ amount per week? _____

Family history:

Please list any illnesses, which run in your family. Include any bleeding disorders, or bad reactions to anesthesia during surgery. _____

Other information you would like the doctor to know: _____