Naugatuck Valley ent Ear, Nose & Throat Associates LLC

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill our every item.** It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcomes to a copy o the report if you with.

Full Name_____Age_____

Pharmacy Preference (include location)_____

Name of Primary Care (Family) Physician_____

Office location of your family doctor_____
Do you want a summary of this visit sent to this medical provider? _____Yes _____No

Race: (Please circle one) American Indian, Alaska Native, Asian, Black/African American, Native Hawaiian/Other Pacific Islander, White, Other:_____

Ethnicity: (Please circle one) Hispanic or Latino Not Hispanic or Latino

Preferred Language: (Please circle one) English Spanish Other:_____

Current Height:_____**Current Weight**:_____

(Current Medications) Are you taking ANY kind of medication now? (This includes prescriptions, over-the-counter or herbal medications) ____Yes ___No If yes, please list below include dosages.

Medication Name	Dosage	How often Taken

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(Medication Allergies) Are you **ALLERGIC TO ANY MEDICATIONS**? __Yes __No

Name of Medication	Type of Reaction (Rash, Swelling, ect.)

Have you had any Surgery or Procedures? _____Yes _____No
If Yes, please list below.

Type of Surgery or Procedure	Date of Surgery or Procedure

What is the Main reason you are here to see a Physician Today?

_____

Please Circle the Reason you are here to see a provider today:
Ears: Wax, Pain, Dizziness, Drainage, Decreased Hearing, Ringing
Nose: Congestion, Drainage, Deviated Septum, Sinus Infection
Mouth/Throat: Sore Throat Ulcer or sore in mouth/throat, Hoarseness, Tonsils
Head: Headache
Neck: Thyroid, Mass or Lump
Other: _____

How long have you been experiencing this problem?
___Hours ___Days ___Months ___Years

Is this a Worker's Compensation related problem? ___Yes ___No
If Yes, When did the injury occur? Date:_____

Did another medical provider refer you to us? If so please tell us who:

_____

Patient Signature:_____Date:_____