Office Use Only

Pulse___________________ Blood Pressure___________________ Misc. ____

KENTUCKIANA EAR, NOSE & THROAT
PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form in its entirety. It is important for your doctor to know you have carefully reviewed every area of this form. Please fill out every item and print clearly. If an item does not apply to you, write n/a in the space. This information will be entered into the computer and you are welcome to request a copy of the report if you wish.

Patient's Last Name ______________________________**First** _______________________ **MI** ________

Date of Birth: ____________________________ **Sex:** ☐ **Male** ☐ **Female**

Email address ____

Race (Mark Only One) □American Indian or Alaskan Native □Asian □Black or African American □Native Hawaiian or Other Pacific Islander □Some Other Race □White □Decline to State

Ethnicity (Mark Only One) □Hispanic or Latino □Not Hispanic or Latino □Decline to State

Preferred Language (Mark Only One) □English □Spanish □Other ________________________________

Name of Primary Care Physician: ____

Name of Physician who referred you to us:____

Pharmacy Preference: Pharmacy Name/phone number____

Address (include City/State)____

What is your □Height _________ □Weight __________

REASON FOR TODAY'S VISIT: ____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATION? ____ Yes ____ No. If yes, please list below:

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATIONS:
Have you ever had any problems with anesthesia (being numbed or put to sleep)? ____Yes ____No
If yes, please list type of problems: ____
____
____

List any surgeries you have had (including dates):
____
____
____
____
____
____
____

Have you ever been hospitalized for non-surgical reasons? ___Yes ___ No
If yes, list reasons for hospitalizations ____
____

Most Recent Diagnostic/Screening Tests: mark all that apply (you can approximate the date if needed).
□Colonoscopy ______/______ (month/year)
□Fecal Occult Blood Testing (FOBT) ______/______ (month/year)
□Sigmoidoscopy - Flexible ______/______ (month/year)
□Pap Smear ______/______ (month/year)
□Mammography ______/______ (month/year)

Immunizations: mark all that apply (you can approximate the date if needed).
□Influenza (Flu) – Has received this vaccine ______/______ (month/year)
□Influenza (Flu) – Never received this vaccine
□Influenza (Flu) – Declined vaccine
□Pneumonia (PPV) – Vaccine given as an adult ______/______ (month/year)
□Pneumonia (PPV) – Revaccination ______/______ (month/year)

CURRENT OR MOST RECENT OCCUPATION: ____