EASTERN SHORE ENT & Allergy ASSOCIATES, P.A.
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PAST MEDICAL HISTORY **Date:** _____/_____/_____

PATIENT NAME ____ **DOB** ____/____/____ **SS#** ______________________

Acid reflux	yes	no	Hyperthyroidism	yes	no	Heart disease	yes	no
Heart attack	yes	no	Hypothyroidism	yes	no	Depression	yes	no
Sleep apnea	yes	no	Kidney disease	yes	no	Asthma	yes	no
Atrial fibrillation	yes	no	Lyme disease	yes	no	Lupus	yes	no
Carotid stenosis	yes	no	Malig. hyperthermia	yes	no	Epilepsy	yes	no
Cataracts	yes	no	Melanoma	yes	no	Thyroid Nodule	yes	no
Congestive heart failure	yes	no	Mitral valve prolapse	yes	no	High cholesterol	yes	no
COPD	yes	no	Multinodular goiter	yes	no	Hepatitis	yes	no
Deep vein thrombosis	yes	no	Organ Transplant	yes	no	High Blood pressure	yes	no
Diabetes	yes	no	Pulmonary embolism	yes	no	Cancer	yes	no
Emphysema	yes	no	Sarcoidosis	yes	no			
End stage renal disease	yes	no	Stroke	yes	no	Type of Cancer ____________________		
Grave's disease	yes	no	Bleeding disorder	yes	no	Other__________________________		

Do you have a pacemaker? Yes or no
Do you have a defibrillator? Yes or no
Do you use CPAP or BiPAP machine? Yes or no

Drug Allergies, including contrast dye: (if yes, list specific reaction)

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Past Surgeries or Hospitalizations:

____

____

Past Family History: (if yes, specify relationship):

Allergies________________________ Hearing loss____________________ Malignant Hyperthermia________________
Cancer__________________________ Heart disease___________________ Stroke________________________________
Diabetes________________________ Hypertension____________________ Other_________________________________

Social History: (please circle answers)

SMOKING
Are you? Current Smoker Former Smoker Non-Smoker
How often do you smoke? Every day Some Days
How many cigarettes/cigars do you smoke a day? < 5 6-10 11-20 21-30 >31
How soon after you wake up do you smoke? 5 min 6-30 min 31-60 min >60 min
Are you interested in quitting? Yes No

ALCOHOL USE
Did you drink alcohol in the past year? Yes No
How often do you drink alcohol? Never Monthly 2-4 Times per Month 2-3 Times per Week >4 Times per Week
When you drink alcohol, how much do you typically drink? 1-2 Drinks 3-4 Drinks 5-6 Drinks 7-9 Drinks >10 Drinks
How often do you have more than 6 drinks on one occasion? Never < Monthly Monthly Weekly Daily

Do you have any religious beliefs, which prohibit Medical Treatment? Yes or No If yes, please explain________________________________