Clear Lake Medical Center ENT

Date:_____

Name: _____ DOB: _____ Signature: _____

Medical advance directive/POA: Y/N Have you fallen in the past year? Y/N Injury? Y/N
Pharmacy name: _____ Pharmacy phone#:_____
Office staff use only: Ht:___ WT:___ BP:___/___ HR:___

Current Medications w/dosages:

_____

_____

_____

_____

Drug allergies:

_____

Past medical history:

- ◊ Asthma/COPD
- ◊ Cancer (Please List): _____
- ◊ Depression
- ◊ Anxiety
- ◊ Diabetes
- ◊ Gastric reflux
- ◊ Heart disease/MI
- ◊ High Cholesterol
- ◊ High Blood pressure
- ◊ Kidney Disease
- ◊ Migraines
- ◊ Seizures
- ◊ Sleep apnea
- ◊ Stomach ulcers
- ◊ Stroke
- ◊ Thyroid disease
- ◊ No changes
- ◊ Other: _____ _____

Past surgical history:

- ◊ Ear tubes
- ◊ Neck surgery
- ◊ Septum surgery
- ◊ Balloon sinuplasty
- ◊ Tonsillectomy
- ◊ Adenoidectomy
- ◊ Vocal cord
- ◊ No changes
- ◊ None
- ◊ Other: _____ _____ _____ _____

Family medical history:
Please list which relative

- ◊Cancer: _____
- ◊Stroke: _____
- ◊Diabetes: _____
- ◊Heart disease: _____
- ◊High blood pressure: _____
- ◊No changes
- ◊Other: _____

Alcohol Use:

- ◊ Never
- ◊ Less than monthly
- ◊ Monthly
- ◊ Weekly
- ◊ Daily

Tobacco use:

- ◊ Never
- ◊ Former
  Yrs of usage:____
- ◊ Current
  Packs per day:____
  Yrs of usage: _____