

# New Patient Health History Form



NASAL & SINUS CENTER  
of AUSTIN

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Marital Status: \_\_\_\_\_ Sex: M F

Home Phone: (\_\_\_\_) \_\_\_\_\_ Alt Phone: (\_\_\_\_) \_\_\_\_\_

If you would like us to send your ongoing medical records to another physician, please list them:

Family Doctor: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_ Other Doctor: \_\_\_\_\_

**Have you been seen by any of the physicians at Capital Otolaryngology? Yes No**

Has a member of your family been seen by any of the physicians at Capital Otolaryngology? Yes (specify) \_\_\_\_\_ No

How did you hear about us? (please circle): Doctor Referral Internet Yellow Pages Insurance Friend Other \_\_\_\_\_

**Reason for today's visit** (please specify how long you have had these symptoms) \_\_\_\_\_

Have you had any tests, scans (CT or MRI), or treatments for this problem: Yes No

If yes, what was done and which doctor ordered them: \_\_\_\_\_

## Answer all questions

### 1. MEDICAL HISTORY

Height \_\_\_\_\_ Weight \_\_\_\_\_

**DO YOU HAVE OR HAVE YOU EVER HAD** (please  box)

- Heart Disease
- Hypertension
- High Cholesterol
- Asthma
- Lung Disease (specify \_\_\_\_\_)
- Seizures, Epilepsy, Fainting or Dizziness
- Bleeding Disorder, Anemia, Blood Transfusion or do you bruise easily
- Liver Disease (Jaundice, Hepatitis)
- Kidney Disease
- Diabetes
- Thyroid Disease ( \_\_\_\_\_)
- Stomach Ulcers or Colitis
- Any disease, drug, or transplant operation that has depressed your immune system
- History of Cancer: Type \_\_\_\_\_ Treatment? \_\_\_\_\_ When diagnosed? \_\_\_\_\_
- Sleep/snoring problems  
Please explain: \_\_\_\_\_
- Hearing problems
- Facial cosmetic concerns  
Concern area: \_\_\_\_\_
- Do you have any other disease, condition or problem that you think the doctor should know about? \_\_\_\_\_  
\_\_\_\_\_
- No known medical conditions

## All responses are kept confidential

### 2. MEDICATIONS

- Do you take any aspirins, Ibuprofen, Advil, Motrin, Vitamin E, or blood thinners?
- Please list all medications you take (include prescription & over-the-counter medications): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 3. SURGICAL HISTORY

Please list any surgeries/hospitalizations you have had (please include date)? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 4. ALLERGIES (write 'none' if you have no known allergies)

- a. Please list any **drug allergies** \_\_\_\_\_  
\_\_\_\_\_
- b. Please list any seasonal allergies or food allergies: \_\_\_\_\_  
\_\_\_\_\_

### 5. SOCIAL HISTORY:

- Do you smoke or chew Tobacco? How much per day? \_\_\_\_\_
- Do you drink Alcohol? How much per day? \_\_\_\_\_
- Do you have a Chemical Dependency or Emotional Disorder that may affect the care we provide you?

### 6. FOR WOMEN ONLY

- Are you pregnant, or is there any chance you might be pregnant?
- Are you nursing?

**X**

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Date