QUEEN CITY
EAR NOSE & THROAT

Medical History Form

Name _____ **Date of Birth** _____

Reason for visit _____

_____

Patient Medical History

Please list any medical conditions you currently have or have had. Please specify if the condition is current or a previous condition.

_____

_____

_____

_____

Family Medical History

Please list any known medical condition of your immediate blood relatives. This would include your parents, grandparents, aunts, uncles, and siblings.

_____

_____

_____

_____

Surgery History

Please list any surgeries you have had. Include surgery dates if possible. If you have a list of your surgeries, please provide the list to the front desk staff.

_____

_____

_____

_____

Monroe Office - 1994 Wellness Blvd, Building C Suite 210, Monroe NC 28110
Blakeney Office - 8924 Blakeney Professional Drive, Charlotte NC 28277
Phone 704-703-1080 Fax 704-703-1090

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Allergies

Please list any allergies you have including environmental, food, and drug allergies. If you have a list of your allergies, please provide the list to the front desk staff.

_____

_____

_____

_____

Current Medications

Please list any medications that you are currently taking including non-prescription medications, vitamins, and supplements. Include dosage if possible. If you have a list of your medications, please provide the list to the front desk staff.

_____

_____

_____

_____

Do you drink alcohol? ☐ Yes ☐ No ☐ Declined to state

If yes, how much/how often? _____

Do you smoke/vape? ☐ Yes ☐ No ☐ Declined to state

If yes, how much/how often? _____

Do you consume caffeine? ☐ Yes ☐ No ☐ Declined to state

If yes, how much/how often? _____

Do you use recreational drugs? ☐ Yes ☐ No ☐ Declined to state

If yes, what type/how often? _____