OTOLARYNGOLOGY PHYSICIANS OF LANCASTER
PATIENT HISTORY FORM

Name: ______________________________ **DOB:** __________ **Age:** ______ **Gender:** ____ **Male** ____ **Female**

Family Doctor ______________________________ **Referring Doctor** ______________________________

Height __________ **Weight** __________ **Are You Pregnant?** **Yes** _____ **No** _____

Patient Medical History – Please Circle if the PATIENT currently has or previously had any of the following			
Acid Reflux/Heartburn/GERD	Depression	High Triglycerides/Cholesterol	Sleep Apnea
Arthritis	Diabetes	HIV	Stroke
Asthma	Heart Disease/Heart Arrhythmia	Kidney Disease	Thyroid Disease
Anxiety	Hearing Difficulty	Lupus	Other:
Cancer	Hepatitis	Migraines	
COPD/Lung Disease	High Blood Pressure	Seizures	

Indicate All Active Patient Medical History		**Health and Preventative Screening**	
CONDITION	Diagnosis Date/Treatment Plan	Screening/Preventative Care	Facility/Date
		Pneumonia Vaccine	
		Influenza Vaccine	

Has the patient ever had General Anesthesia? Yes No

Patient Past Surgical History – Please circle			
Adenoids	Hernia	Parotid	Tonsils
Angioplasty	Hysterectomy	Sinus/Septoplasty	Tubes
Bypass	Lung	Stent	Other
Esophageal	Mastoid	Skin	
Gallbladder	Pacemaker	Thyroid	

Medications – Please list all medications the patient is currently taking – use back of form if need be.			
Name of Medication	Dosage/Times per Day	Route	Reason

Medication Allergies – Use back of form if need be.	
Name of Medication	Reaction

Primary Pharmacy ______________________

Pharmacy Location & Phone ______________________

FAMILY Medical History – Please Circle if any **FAMILY** member currently has or previously had any of the following. **PLEASE INDICATE RELATION.**			
Acid Reflux/Heartburn/GERD	COPD/Emphysema	High Triglycerides/Cholesterol	Seizures
Arthritis	Diabetes	HIV/Hepatitis	Sleep Apnea
Asthma	Heart Disease/Heart Arrhythmia	Kidney Disease	Stroke
Anxiety/Depression	Hearing Difficulty	Lupus	Thyroid Disease
Cancer	High Blood Pressure	Migraines	Other:

Please circle social behavior and indicate how often, if former indicate former.			
Social Behavior	How Much? & How Often?	Social Behavior	How Much? & How Often?
Alcohol		Q-Tips	
Caffeine		Street/Recreational Drugs	
Tobacco – smoke or chew		Other:	