GREENWOOD
EAR | NOSE | THROAT

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HEALTH SUMMARY

Patient Name: _____ Date: _____

Birth Date: ___ /___ /_____

Height: _____ Weight: _____ lb.

Yes No
☐ ☐ Do you have any allergies? If yes please list

_____ _____

_____ _____

_____ _____

What pharmacy do you use: _____

Address: _____ City: _____ State: _____

Yes No
☐ ☐ Medications? If yes what medications are you taking (including birth control pills, herbals, vitamins, dietary supplements and over the counter?)

_____ _____

_____ _____

_____ _____

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Present Health Conditions

Yes	No	Disease		Yes	No	Disease
		Irregular Heart Beat				Prostate Problems
		Congestive Heart Failure				Gout
		Heart Attack				Arthritis
		Heart Murmur				Skin Disease, Type: _____
		Rheumatic Fever				Stroke
		High Cholesterol				Epilepsy/Seizures
		High Blood Pressure				Diabetes/High Blood Sugar
		Asthma				Thyroid Problems, Too High Too Low
		Emphysema/Chronic Bronchitis				Anemia/Low Blood
		Blood Clot Lung				Bleeding Problems, Type: _____
		Blood Clot Leg				Blood Transfusion
		Tuberculosis				Cancer, Type: _____
		Gallstones				Anxiety
		Liver Disease, Type: _____				Depression
		Ulcers in Bowels/Stomach				Glaucoma
		Bleeding from Bowels		Other: _____		
		Kidney Disease, Type: _____				
		Kidney Stones				

Surgeries

Yes	No	Surgery		Yes	No	Surgery
		Cataract Surgery ☐ Left ☐ Right				Joint Replacement of Hip/Knee
		Tonsils Removed				Back Disc Surgery
		Neck Artery Surgery				Prostate Surgery
		Open Heart Surgery/Catheterization				Hernia Surgery
		Appendectomy				Vasectomy
		Gallbladder Removal				Hysterectomy
		Abdominal Surgery		Other: _____		
		Broken Bone Repair				
		Joint Scope Surgery				

HEALTH SUMMARY CONTINUED

Family History

Yes	No	Disease	Relationship to you
		Heart Attack	
		High Blood Pressure	
		High Cholesterol	
		Asthma	
		Tuberculosis	
		Liver Disease	
		Kidney Disease	
		Gout/Arthritis	
		Osteoporosis	
		Stroke	
		Epilepsy/Seizures	
		Anxiety or Depression	

Yes	No	Disease	Relationship to you
		Bleeding Problems	
		Sickle Cell Anemia	
		Diabetes/ High Blood Sugar	
		Thyroid Problems	
		Cancer Type: _____	
		Alcohol Abuse	
		Glaucoma	
Other: _____			

Other History

Exercise: ☐ Never ☐ Rarely ☐ Other: _____

When was your last:

Tetanus: _____ ☐ Never Pneumovax: _____ ☐ Never

Hepatitis B: _____ ☐ Never Flu Shot: _____ ☐ Never

Smoking:

Yes	No		
☐	☐	Have you ever smoked	How many years did you smoke? _____
☐	☐	Do you use smokeless tobacco?	When did you quit? _____
			How many packs per day do you smoke now? _____

The following questions are very important and strictly confidential. Please answer them accurately.

Alcohol/Drugs

Yes	No				
☐	☐	Do you drink?	How much? _____	How Often? _____	
☐	☐	Do you use drugs?	How much? _____	How Often? _____	What kind? _____

What Drugs have you used in the past? _____

_____

The above information is current and correct to the best of my knowledge. I have reviewed the above history

_____ _____ _____ _____

Patient / Guardian Signature *Date* *Physician's Initial* *Date*