GREENWOOD
EAR | NOSE | THROAT

www.greenwoodentdoctors.com

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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?)

_____ _____

_____ _____

_____ _____

-

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		Yes	No	Disease	Relationship to you
		Heart Attack					Bleeding Problems	
		High Blood Pressure					Sickle Cell Anemia	
		High Cholesterol					Diabetes/ High Blood Sugar	
		Asthma						
		Tuberculosis					Thyroid Problems	
		Liver Disease					Cancer Type: _____	
		Kidney Disease						
		Gout/Arthritis					Alcohol Abuse	
		Osteoporosis					Glaucoma	
		Stroke			Other: _____			_____
		Epilepsy/Seizures						_____
		Anxiety or Depression						_____

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*