

MEDICAL HISTORY

To be completed by patient – PLEASE PRINT

Everett Ear Nose Throat Sinus and Allergy

Glenn W. Drumheller, DO --- Thomas J. Mueller, MD

What is your primary complaint today / What is the reason for your visit? _____

Have you ever had or do you currently have any of the following:

- High Blood Pressure Yes / No
- Heart Disease Yes / No Stroke ___ Bypass ___ Stent ___ Other: _____
- Diabetes – Self Yes / No List relatives with _____
- Ulcer Yes / No Is the condition healed? _____
Bleeding ulcer? _____
- Pneumonia Yes / No Year? _____
- Hepatitis Yes / No List type: _____
- Asthma Yes / No List treatment: _____
- Cancer Yes / No List type: _____
- Tuberculosis Yes / No Current/Active ___ Not active ___
- Thyroid Condition Yes / No
- High Cholesterol Yes / No
- Other: _____

Please list all current MEDICINES (including over the counter medications). If possible, list the name, dose and name of prescribing doctor, if applicable.

No medications at this time

Medication list attached

- | | |
|----------|-----------|
| 1) _____ | 6) _____ |
| 2) _____ | 7) _____ |
| 3) _____ | 8) _____ |
| 4) _____ | 9) _____ |
| 5) _____ | 10) _____ |

Do you have any medication ALLERGIES? List all, including over the counter medications).

None

- | | |
|----------|----------|
| 1) _____ | 4) _____ |
| 2) _____ | 5) _____ |
| 3) _____ | 6) _____ |

Please list all SURGERIES that you have had in your lifetime.

None

- | | |
|----------|------------|
| 1) _____ | Year _____ |
| 2) _____ | Year _____ |
| 3) _____ | Year _____ |
| 4) _____ | Year _____ |

Do you use tobacco? Yes / No - Smoke / Chew: How much _____ How often _____

If you have quit smoking, How long ago _____ How much you smoked _____

Caffeine intake, including soda, tea, coffee: Cups per Day _____ Week _____ Month _____

Alcohol intake: please circle daily / weekly / monthly / rarely / never

Do you have dentures? Yes / No please circle Full / partial / uppers / lowers

Are you currently undergoing any dental treatment? _____

Pharmacy Name/Location _____ Phone number _____

Patient Name (please print) _____ Date: _____