MED CENTER HEALTH | ENT Bowling Green

Patient Name: _____

Height: _____Weight: _____ DOB: _____

Medical History

Have you ever had or do you have any of the following medical problems?
(Please circle all that apply)

Alcoholism	Diabetes	Liver Problems
Anemia	Emphysema	Lung Problems
Arthritis	Glaucoma	Lupus
Asthma	Hearing Loss	Mental Illness
Birth Defect	Heart Attack/Angina	Stroke
Bladder Disease	Heart Failure	Seizures
Bleeding Disorder	High Blood Pressure	Sexually Transmitted Disease
Cancer	Kidney Problems	Thyroid Problems

List all food/Medication Allergies. _____

Date of your last flu shot? _____

Date of your last pneumonia shot? _____

List any medical problems not listed above: _____

_____

List all surgeries you've had. _____

_____

Family History

Has anyone in your family had any of the following medical problems?
(Please indicate Relative: F=father, M=mother, G=grandparent, S=sibling)

____Alcoholism	____Diabetes	____Liver Problems
____Anemia	____Emphysema	____Lung Problems
____Arthritis	____Glaucoma	____Lupus
____Asthma	____Hearing Loss	____Mental Illness
____Birth Defect	____Heart Attack/Angina	____Stroke
____Bladder Disease	____Heart Failure	____Seizures
____Bleeding Disorder	____High Blood Pressure	____Sexually Transmitted Disease
____Cancer	____Kidney Problems	____Thyroid Problems

Social History

Occupation _____

Are you currently using tobacco products? _____ How much? _____ How Long? _____

Have you ever used tobacco products? _____ How much? _____How Long? _____

Are you exposed to secondhand smoke? _____ How often? _____

Do you use alcohol? _____ How much? _____ How Long? _____

Are you currently using recreational drugs? _____ How much? _____ How Long? _____ Have you ever? _____

LIST ALL MEDICATIONS