## Minneapolis Otolaryngology, PA
## PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. Please fill out every item. It is important for your doctor to know you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

**TODAY'S DATE:** _____ **REASON FOR TODAY'S VISIT:** _____

**Patient's Last Name:** _____ **First:** _____ **MI:** _____

**Sex:** Male Female **Date of Birth:** _____ **Height:** _____ **Weight**: _____

**Marital Status:** Married Divorced Single Widowed **Spouses Name**: _____

**Referring Physician:** _____ **Pharmacy:** _____

**Race:** _____ **Ethnicity:** Hispanic / non-Hispanic / decline to state **Preferred language:** English / Spanish / Other

**Current / most recent occupation:** _____ **Employer:** _____

| | | | |
|---|---|---|---|
| **Have you had a flu shot within the last year?** | YES | NO | _____ year |
| **Have you had a pneumonia vaccination?** | YES | NO | _____ year |
| **Have you had a colonoscopy within the last 10 years?** | YES | NO | _____ year |
| **Have you had a flexible sigmoidoscopy within the last 4 years?** | YES | NO | _____ year |
| **Have you had a pap smear within the last 2 years?** | YES | NO | _____ year |
| **Have you had a mammogram within the last year?** | YES | NO | _____ year |

**PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:** (Use back of sheet if necessary.)

| Prescribed Medications and Dosage | How Often Taken | Reason for Taking |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| OTC Medication | | |
| | | |
| | | |
| | | |
| Herbal Medications | | |
| | | |
| | | |

**ARE YOU ALLERGIC TO ANY MEDICATION? _____ YES _____ NO**

| Name of Medication | Type of Reaction |
|---|---|
| | |
| | |
| | |

**SURGICAL HISTORY:**

| Name of Surgery/Procedure | Date (approximate) |
|---|---|
| | |
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