Patient Health History
Orlando ENT

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.

Patient's Last Name _____ First _____Mi_____
(Apellido) (Nombre)

Sex: ☐ Male ☐ Female Date of Birth_____ Race _____
(Masculino) (Femenino) (Fecha de Nacimiento) (Raza)

Height: _____ Weight:_____ Occupation: _____
(Estatura) (Peso) (Ocupacion)

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino Preferred Language:_____

Name of Primary Care Physician: _____
(Nombre de medico primario)

Pharmacy Preference: (including location) _____
(Farmacia: incluyendo direccion)

Reason For Today's Visit: _____
(Razon para la visita)

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:
(Medicamentos que esta tomando)

Name of Medication	How Often Taken	Dosage

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ Yes ☐ No. If yes, please list below:
(Alergico(a) a medicamentos?)

Name of Medication (Nombre del Medicamento)	Type of Reaction (Reacciones)

SURGERIES AND HOSPIALIZATIONS

Have you ever had any problems with anesthesia (being numbed or put to sleep)? Yes☐ No ☐
(Ha tenido problemas con Anestesia?)

If yes, please list type of problems: _____

_____

List any surgeries you have had (including dates): _____
(Lista de cirugias que ha tenido) _____

Have you ever been hospitalized for non-surgical reason? Yes☐ No ☐
(Ha estado hospitalizado(a) por razones que no sea de cirugia?)

If yes, list reasons for hospitalizations: _____

Signature: _____ Date: _____
(firma) (fecha)

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