

DALLAS ENT GROUP

Ambulatory History

Patient Name _____ DOB _____ Age _____ Today's Date _____

Pharmacy Name _____ Phone# _____

Referring Physician or whom may we thank for referring you? _____

Primary Care Physician and Number _____

Why are you here today? _____

How long have you had this problem? _____

Is this visit related to an accident? _____ DOA: _____

Was this a Motor Vehicle Accident? _____

Past Medical History:

Please list all medications you are presently taking, including prescription, samples, over the counter, and any herbal medications:

Allergies to medications: No ___ Yes ___ Please list: _____

Allergic to Latex: No ___ Yes ___ Please list: _____

Previous Surgery: No ___ Yes ___ Please list: _____

Hospitalizations: No ___ Yes ___ Please list: _____

Tobacco (any form) No ___ Yes ___ Kind & Amount _____

Alcohol: No ___ Yes ___ If yes, occasional _____ Moderate _____ More than moderate _____

Review of Medical Systems (Explain if you answer yes to any of the following problems)

Heart No ___ Yes ___ _____

Kidney or Bladder No ___ Yes ___ _____

Lung No ___ Yes ___ _____

Neurological/Stroke No ___ Yes ___ _____

Diabetes No ___ Yes ___ _____

Thyroid No ___ Yes ___ _____

High Blood Pressure No ___ Yes ___ _____

Bleeding Problems No ___ Yes ___ _____

Glaucoma No ___ Yes ___ _____

Stomach, intestine,

liver, or bowel No ___ Yes ___ _____

Family History of

bleeding problems No ___ Yes ___ _____

Cancer of any form No ___ Yes ___ _____

Any family history of problems with **anesthesia**? No ___ Yes ___

Does your insurance require you to use a specific hospital or lab? No ___ Yes ___

Females: Are you pregnant or suspect that you might be? No ___ Yes ___

Patient signature (Parent, if minor) _____ Relation to Patient _____

Physician signature _____ Date _____