RAVAL FACIAL AESTHETICS and ENT, P.C.

Patient Health History Form

In order for us to obtain a comprehensive medical history, it is important for you to fill out this form completely.

Appointment Date_____________ **Full Name**____

Reason for Visit ____

Pharmacy Name ____ **Phone #** ___________________

Name of Primary Care Physician______________________________ **Phone#**___________________

CURRENT MEDICATIONS

Are you taking ANY kind of medication now? (This includes prescription, over the counter, or herbal medications)

YES ☐ **NO** ☐

Medication Name	Dosage	How often taken

MEDICATION ALLERGIES: Are you allergic to any medications? YES ☐ **NO** ☐

Name of Medication	Type of Reaction

NON-MEDICATION ALLERGIES:

Are you allergic to anything in the environment such as pollens, dust, food, etc.? YES ☐ **NO** ☐

If yes, please indicate what you are allergic to: ____

Past Health History:

Have you ever been diagnosed with any major medical problem? YES ☐ **NO** ☐

If yes, please list below.

Medical Condition	Year Diagnosed

Have you ever been hospitalized? YES ☐ **NO** ☐

If yes please list below.

Reason for Hospitalization	Date of Hospitalization

Have you had any previous surgeries? YES ☐ **NO** ☐

If yes please list below.

Type of Surgery	Date of Surgery

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Have you had any problems with anesthesia? YES ☐ NO ☐

If yes please list what sort of problems. ____

Family History:

Specific Anesthesia Problem	Mother ☐	Father ☐	Brother ☐	Sister ☐
Ears:				
Hearing Loss before age 20	Mother ☐	Father ☐	Brother ☐	Sister ☐
Hearing Loss after age 20	Mother ☐	Father ☐	Brother ☐	Sister ☐
Nose and Sinus:				
Nasal Allergies	Mother ☐	Father ☐	Brother ☐	Sister ☐
Nasal Polyps	Mother ☐	Father ☐	Brother ☐	Sister ☐
Heart and Blood Vessels:				
Heart Disease	Mother ☐	Father ☐	Brother ☐	Sister ☐
High Blood Pressure	Mother ☐	Father ☐	Brother ☐	Sister ☐
Lungs and Respiratory:				
Asthma	Mother ☐	Father ☐	Brother ☐	Sister ☐
Lung Cancer	Mother ☐	Father ☐	Brother ☐	Sister ☐
Brain and Nervous System:				
Stroke	Mother ☐	Father ☐	Brother ☐	Sister ☐
Blood & Lymph Node:				
Bleeding/Clotting	Mother ☐	Father ☐	Brother ☐	Sister ☐
Other Problems: ____________________	Mother ☐	Father ☐	Brother ☐	Sister ☐

Social History:

Do you use tobacco? Yes ☐ No ☐ If yes what type? ____________________ How Often____________

Do you consume alcohol? Yes ☐ No ☐ If yes what type? ____________________ How Often____________

Review of Systems: List any problems the patient has or recently had in the following areas.

General Health:	Yes ☐	No ☐	If yes please explain________________________
Head/Neck:	Yes ☐	No ☐	If yes please explain________________________
Eyes:	Yes ☐	No ☐	If yes please explain________________________
Ears:	Yes ☐	No ☐	If yes please explain________________________
Nose/Sinus:	Yes ☐	No ☐	If yes please explain________________________
Mouth/Throat:	Yes ☐	No ☐	If yes please explain________________________
Heart:	Yes ☐	No ☐	If yes please explain________________________
Lungs/Resp:	Yes ☐	No ☐	If yes please explain________________________
Digestive:	Yes ☐	No ☐	If yes please explain________________________
Female Health:	Yes ☐	No ☐	If yes please explain________________________
Bone/Joint:	Yes ☐	No ☐	If yes please explain________________________
Skin:	Yes ☐	No ☐	If yes please explain________________________
Brain:	Yes ☐	No ☐	If yes please explain________________________
Mental:	Yes ☐	No ☐	If yes please explain________________________
Blood:	Yes ☐	No ☐	If yes please explain________________________
Allergies/Immun:	Yes ☐	No ☐	If yes please explain________________________
Glands/Hormone:	Yes ☐	No ☐	If yes please explain________________________