Wilmington Otolaryngology Associates

PATIENT HEALTH HISTORY

PLEASE FILL OUT FRONT AND BACK

Patient's Last Name_____First_____MI_____

Gender_____Race_____Ethnicity_____DOB_____

Preferred Language_____Primary Care Provider_____

Pharmacy (include location)_____

Current or most recent Occupation_____

Reason for Today's Visit: _____

MEDICATION LIST:

NAME	DOSAGE	FREQUENCY

MEDICATION ALLERGIES: YES_____ NO_____ If yes, please list below:

NAME	REACTION

SURGERIES AND HOSPITALIZATONS:

Have you ever had any problems with anesthesia (being numbed or put to sleep)? YES_____ NO_____

If yes, what kind of problem? _____

_____

_____

List any surgeries you have had (including dates): _____

_____

_____

_____

Have you ever been hospitalized for a non-surgical reason? YES _____ NO _____

If yes, list reasons for hospitalization(s) _____

_____

_____

Height _____ Weight _____

COVID Vaccine? Y / N If yes, what kind and how many? _____

Influenza Vaccine? Y / N Most recent (month and year) _____

Pneumonia Vaccine? Y / N Most recent (just year) _____

For patients aged 50 – 75, have you had the following screening tests / exams:

Colonscopy Y / N Most recent year done _____

Mammogram Y / N Most recent year done _____