Chevy Chase ENT Associates, LLC
Medical History

Date:______________

Name: ____ Age:_______ Weight:________ Height:_______

Are you allergic to any medications? ☐no ☐yes Please list:____

Medications you are currently taking: ☐NONE

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Medical problems you have or are currently being treated for: ☐NONE

Respiratory: ☐sleep apnea ☐C-PAP ☐asthma ☐emphysema ☐bronchitis

Cardiac: ☐high blood pressure ☐high cholesterol ☐atrial fibrillation ☐mitral valve prolapse ☐pacemaker
☐palpitations ☐chest pain or angina ☐heart failure ☐heart attack (year_____________)

Gastrointestinal/Liver disease: ☐ulcers ☐hiatal hernia ☐acid reflux ☐liver failure

Hematologic: ☐bleeding or clotting issues ☐taking a blood thinner ☐ ☐anemia

Endocrine: ☐diabetes ☐thyroid disease

Renal/Urinary: ☐kidney stones ☐kidney failure/insufficiency ☐enlarged prostate

Infectious disease: ☐hepatitis ☐HIV ☐mono ☐herpes ☐tuberculosis ☐Lyme disease

Psychiatric: ☐depression ☐anxiety ☐claustrophobia

Neurologic: ☐seizures ☐stroke ☐neck injury ☐back injury

Ophthalmologic: ☐glaucoma ☐cataracts ☐macular degeneration

Hearing: ☐hearing loss ☐hearing aids ☐tinnitus ☐vertigo

History of Cancer: ☐no ☐yes What kind? _____________ Treatment received: ______________________________

Any other medical problems not listed above? ☐no ☐yes Describe: ____

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____

____

What surgeries have you undergone? ☐NONE

☐tonsillectomy ☐nasal or sinus surgery ☐ear surgery ☐appendectomy ☐hernia repair ☐gallbladder removed

☐other surgeries: ____

____

Do you require antibiotics for dental cleanings or for certain surgeries? ☐no ☐yes

Have you ever had a reaction to anesthesia? ☐no ☐yes Describe: ____

Have you ever had a reaction to x-ray dyes? ☐no ☐yes Describe: ____

Have you ever used tobacco products? ☐never ☐currently ☐previously Quit date: ________________

What type? ☐cigarettes ☐cigars ☐pipe ☐chewing tobacco

Amount and frequency: ___________________________

Have you ever used recreational drugs? ☐no ☐yes What kind? ____________________________

Do you drink alcoholic beverages? ☐no ☐yes Amount and frequency: ___________________________

Do you drink caffeinated beverages? ☐no ☐yes Amount and frequency: __________________________

Do you grind your teeth? ☐no ☐yes

Do you chew gum? ☐no ☐yes