CHEVY CHASE
ENT & AUDIOLOGY

Medical History Form

Name: _____ Age: _____ Weight: _____ Height: _____

Are you allergic to any medications? ☐ No ☐ Yes Please list: _____

Medications you are currently taking: ☐ None

_____

_____

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: _____

_____

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