

**PUGET SOUND OTOLARYNGOLOGY, INC., P.S.
HEALTH FORM**

Patient Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Height: _____ **Weight:** _____

List current medications and dosages (include over the counter medications, herbal medications, etc)

Medication Allergies: _____

Pregnant or nursing: yes _____ no _____

List previous surgeries/medical problems and dates (not mentioned above): _____

Check and explain all that apply:

Cardiovascular:

- heart murmur, irregular heart beat
- heart attack , heart surgery
- heart valve, pacemaker , defibrillator
- high blood pressure

- chest pain (angina)
- stroke, blood clots, circulation problems
- do you take medication to thin the blood
- other _____

Respiratory:

- asthma, wheezing
- emphysema/COPD
- TB

- lung surgery
- chronic cough, shortness of breath
- other _____

Gastrointestinal/Genitourinary:

- heartburn, reflux, ulcers
- liver problems, hepatitis
- other _____

- hiatal hernia
- kidney, urinary problems

Musculoskeletal:

- joint replacements, implants, pins
- arthritis, paralysis
- artificial limbs

- must you take antibiotics before dental/oral work
- physical limitations
- other _____

Neurologic/Psychiatric:

- fainting, seizures
- developmentally delayed/handicapped
- depression

- mental, psychiatric problems
- ADD/ADHD
- other _____

DR. REVIEW

