PATIENT HEALTH HISTORY QUESTIONAIRE
PHILLIP N. CHIRONIS, MD

PURPOSE OF TODAY'S VISIT? **CIRCLE:** **AGE:**_____

EARS **NOSE** **THROAT** **SINUS** **NECK**

EXPLAIN_____

PAST MEDICAL HISTORY:

_____

HAVE YOU HAD ANY OF THE FOLLOWING: (CIRCLE ONE OR MORE)

DIABETES, STROKE, CANCER, HEART DISEASE, HIGH BLOOD PRESSURE, KIDNEY PROBLEMS, LUNG PROBLEMS, FRACTURED BONES, VISUAL PROBLEMS, BLEEDING PROBLEMS, AIDS OR HIV:

OTHER:
EXPLAIN_____

PREVIOUS SURGERY: (LIST)
_____
_____
_____

CURRENT MEDICATIONS:
_____

ALLERGIC TO MEDICINES:
(LIST)_____

OCCUPATION_____ **HOW LONG** _____

CIGARETTES: YES NO **HOW MANY PACKS/DAY**_____
ALCOHOL: YES NO **HOW MANY DRINKS/WEEKS**_____
SUBSTANCE ABUSE: YES NO **TYPE:**_____

WEIGHT:_____ **HEIGHT:**_____

PHYSICIANS THAT CARED FOR YOU WITHIN THE LAST YEAR?
_____

DATE:_____
SIGNATURE_____