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PATIENT MEDICAL HISTORY FORM

(The following information is very important to your health. Please take the time to fully and completely fill out both sides. This is important information and we are counting on you.)

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Any recent diagnostic tests for this problem? \_\_\_\_\_

Who is your PCP? \_\_\_\_\_ Who referred you to this office? \_\_\_\_\_

ALLERGIES:

Are you allergic to any medicines (including any tape, iodine or latex)

No Yes (If yes, please complete the allergy information below)

Medications: \_\_\_\_\_ Type of reaction you experience: \_\_\_\_\_

Table with 2 columns: Medications, Type of reaction you experience.

PAST SURGICAL HISTORY:

Type of operation: \_\_\_\_\_ Date or age at time of operation \_\_\_\_\_

Table with 2 columns: Type of operation, Date or age at time of operation.

CURRENT MEDICATIONS:

Medication Dose Frequency Medication Dose Frequency

Table with 6 columns: Medication, Dose, Frequency, Medication, Dose, Frequency.

Are you required to take antibiotics before procedures? Yes No

Are you on Oxygen or CPAP? Yes No

Is there a chance you may be pregnant? Yes No

SOCIAL HISTORY: yes no

Do you smoke? If yes, how much per day and how many years? \_\_\_\_\_

Have you ever smoked? If yes, start date/quit date? \_\_\_\_\_

Do you drink alcohol? If yes, how much, how often? \_\_\_\_\_

Are you exposed to second hand smoke? Yes No

What is your occupation? \_\_\_\_\_ Who currently lives in your home? \_\_\_\_\_

FAMILY MEDICAL HISTORY:

yes no (relationship to you) yes no (relationship to you)

Cancer \_\_\_\_\_ Bleeding problem \_\_\_\_\_

High blood pressure \_\_\_\_\_ Diabetes \_\_\_\_\_

Heart problems \_\_\_\_\_ Seizures/epilepsy \_\_\_\_\_

Hepatitis \_\_\_\_\_ Asthma \_\_\_\_\_

Unusual reaction to anesthesia? \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_ (v.5/1/06)

(The information provided on both sides of this form is true and correct to the best of my belief)

"Healing with Heart, Head and Hands"

**MEDICAL HISTORY (continued) Patient Name \_\_\_\_\_**

Have you been diagnosed with or are currently having problems with any of the following:

<u>Cardiac (heart/circulation)</u>	yes	no		yes	no		yes	no
Chest Pain			Heart murmur			Rheumatic fever		
Congestive heart failure			Heart attack			Irregular heart beat		
High blood pressure			Pacemaker					
Heart valve problems			Palpitations					
<u>Pulmonary (lung)</u>	yes	no		yes	no		yes	no
Shortness of breath			Asthma			Recurrent cough		
Wheezing			Chest tightness			Bloody cough		
Emphysema/COPD			Lung cancer			Productive cough		
Pulmonary embolism			Recurrent bronchitis					
<u>Digestive (stomach/intestines)</u>	yes	no		yes	no		yes	no
Heart burn			Acid reflux disease			Cirrhosis		
Ulcers			Pancreatitis			Crohn's/Colitis		
Abdominal pain			Diverticulitis			Irritable bowel syndrome		
<u>Kidney</u>	yes	no		yes	no		yes	no
Kidney Failure			Recurrent kidney infection			Urinary retention		
<u>Endocrine (hormone)</u>	yes	no		yes	no		yes	no
Thyroid problems			High blood sugar			Diabetes		
Chronic fatigue			Excessive thirst			Lupus		
<u>Hematologic (blood)</u>	yes	no		yes	no		yes	no
Anemia			Leukemia			Clotting problem		
Immune deficiency								
<u>Infectious Disease</u>	yes	no		yes	no		yes	no
Hepatitis (A, B, or C)			AIDS/HIV			Tuberculosis		
Chronic fatigue syndrome			Chronic Epstein-Barr					
<u>Musculoskeletal</u>	yes	no		yes	no		yes	no
Chronic back problems			Chronic neck problems			Fibromyalgia		
TMJ Syndrome			Arthritis			MS or MD		
<u>Skin</u>	yes	no		yes	no		yes	no
Psoriasis			Eczema			Jaundice		
<u>Neurologic</u>	yes	no		yes	no		yes	no
Seizure			Stroke/TLA			Migraine headaches		
Multiple Sclerosis			Parkinson's			Numbness		
Loss of strength								
<u>Psychologic</u>	yes	no		yes	no		yes	no
Depression			Anxiety/nervousness			Paranoia		
Bipolar Disorder			Schizophrenia					
<u>Immune system</u>	yes	no		yes	no		yes	no
Lupus			Autoimmune disease			Immune deficiency		

Cancer

Type: \_\_\_\_\_ First diagnosed: \_\_\_\_\_

Treatment: \_\_\_\_\_

Other

Do you have any reactions with anesthesia? \_\_\_\_\_

Do you have any other health conditions that are not listed? \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_ (v.5/1/06)