MinnesotaENT
EAR NOSE AND THROAT SPECIALISTS

Patient Health History

For us to obtain a complete medical history, it is important for you to fill out this form as completely as possible.

Patient Name: _____ Date of Birth: _____

If a minor, Parent/Guardian Name(s): _____

❑ Male ❑ Female Height: _____ Weight: _____ Preferred Language: _____

Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ White
❑ Native Hawaiian or other Pacific Islander ❑ Unspecified/Other ❑ Declined to Specify

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unspecified ❑ Declined to Specify

Primary Care Physician: _____ Referring Physician: _____

Pharmacy: _____ Location: _____ Phone: _____

To respect your privacy, how can we reach you regarding your health information, lab test results, medication, or billing?

Preferred Phone: _____ May we leave a message? ❑ Yes ❑ No

REASON FOR TODAY'S VISIT: _____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

WHAT TREATMENT(S) HAVE YOU RECEIVED? _____

WHAT TESTS HAVE BEEN PERFORMED? _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: ❑ SEE ATTACHED LIST
(Include aspirin, ibuprofen, vitamins, fish oil, over-the-counter medications, etc.)

Name of Medication	Dosage	Name of Medication	Dosage
1.		5.	
2.		6.	
3.		7.	
4.		8.	

ARE YOU ALLERGIC TO ANY MEDICATION? ❑ Yes ❑ No If yes, please list below:

Name of Medication/Reaction	Name of Medication/Reaction
1.	5.
2.	6.
3.	7.
4.	8.

SURGICAL HISTORY: (If you completed the online survey, skip this section.)

Type of Surgery/Procedure and Year it Occurred	Type of Surgery/Procedure and Year it Occurred
1.	5.
2.	6.
3.	7.
4.	8.

Signature: _____ Date: _____