Ear, Nose & Throat & Facial Plastic Surgery Center of Fredericksburg
1708 Fall Hill Avenue, Suite 100 - Fredericksburg, Virginia 22401
(540) 371-1226

Medical History Form

Chart: ______________________ (For Office Use Only)

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Patient Name ______________________ Date ____________
Last First Middle

Review of Symptoms and Past Medical History

Please indicate whether you have had any of the symptoms or conditions listed below:

GENERAL	Now	Past	Never
Unexplained Weight gain or loss	☐	☐	☐
Chronic fatigue	☐	☐	☐
Fever/ Night sweats	☐	☐	☐
HEART			
Chest pain	☐	☐	☐
Varicose veins	☐	☐	☐
Ankle swelling	☐	☐	☐
Leg cramps when walking	☐	☐	☐
EYES			
Double vision	☐	☐	☐
Change in vision	☐	☐	☐
EARS, NOSE, THROAT			
Noise Exposure	☐	☐	☐
Head injury/ Concussion	☐	☐	☐
Draining or painful ears	☐	☐	☐
Hearing Loss	☐	☐	☐
Ringing in ears	☐	☐	☐
Dizziness/ loss of balance	☐	☐	☐
Facial pain or headaches	☐	☐	☐
Nasal congestion/ drainage	☐	☐	☐
Frequent nosebleeds	☐	☐	☐
Difficulty Swallowing	☐	☐	☐
Hoarseness	☐	☐	☐
Snoring/ Sleep apnea	☐	☐	☐
PULMONARY			
Chronic Cough	☐	☐	☐
Asthma/ Wheezing	☐	☐	☐
Shortness of Breath	☐	☐	☐
Coughing up Blood	☐	☐	☐
BONE AND JOINT			
Jaw pain	☐	☐	☐
Joint pain/ swelling	☐	☐	☐
GASTROINTESTINAL			
Frequent Heartburn	☐	☐	☐
Indigestion	☐	☐	☐
Frequent or severe stomach pain	☐	☐	☐
Frequent or severe vomiting	☐	☐	☐
Frequent diarrhea	☐	☐	☐

NERVOUS SYSTEM	Now	Past	Never
Fainting Spells	☐	☐	☐
Seizures/ Epilepsy	☐	☐	☐
Shaking/ Tremors	☐	☐	☐
Numbness	☐	☐	☐
Tingling arms, legs	☐	☐	☐
HEMATOLOGY			
Anemia	☐	☐	☐
Enlarged lymph nodes	☐	☐	☐
DERMATOLOGY			
Skin rash	☐	☐	☐
Unusual moles	☐	☐	☐
URINARY			
Frequent Urination	☐	☐	☐
Trouble holding urine	☐	☐	☐
Trouble starting urine	☐	☐	☐
Awakening to urinate	☐	☐	☐
FEMALES			
Pregnant	☐	☐	☐
Number of pregnancies	☐		
Live Births	☐		
PSYCHIATRIC			
Anxiety	☐	☐	☐
Depression	☐	☐	☐
Panic attacks	☐	☐	☐
Problems falling asleep	☐	☐	☐

Other Family Members seen in this office:

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Chart: ______________________________
(For Office Use Only)

Patient Name [ ] Date [ ]

Past Surgeries: List type of operation, place and date:

Medications: List dose and frequency. Include Non-Prescription Medicines, herbal supplements and/or vitamins

Health History: Have you had any of the following?

	YES	NO
Cancer	☐	☐
Heart Murmur	☐	☐
High blood pressure	☐	☐
Liver disease, jaundice, Hepatitis	☐	☐
Pneumonia	☐	☐
Artificial joints or heart valves	☐	☐
Serious injury/ accident	☐	☐
Diabetes	☐	☐
Tuberculosis	☐	☐

	YES	NO
Kidney Disease	☐	☐
HIV / AIDS	☐	☐
Difficulty with anesthesia	☐	☐
Heart Attack	☐	☐
Thyroid Disease	☐	☐
Abnormal EKG	☐	☐
Stroke	☐	☐
Facial Fracture	☐	☐
Uncontrolled bleeding	☐	☐

Do you take antibiotics when you go to the Dentist? ☐ Yes ☐ No

Have you taken Aspirin within the last two weeks? ☐ Yes ☐ No If so, How much? [ ]

Is this visit the result of an accident? ☐ Yes ☐ No If so, date of the accident? [ ]

Drug Allergies:

Social History:

Smoking: Cigarettes ☐ Pipe ☐ None ☐ Quit ☐

Number of years: [ ]

Alcohol: Beer ☐ Wine ☐ None ☐ Quit ☐

Amount per week: [ ]

Do you use Marijuana? ☐ Yes ☐ No

Do you use other recreational drugs? ☐ Yes ☐ No

Family Health History

		Present Health			If Deceased	
	Age	Good	Fair	Poor	Age at Death	Cause of Death
Mother		☐	☐	☐		
Father		☐	☐	☐		
Sibling		☐	☐	☐		
Children		☐	☐	☐		