PATIENT HEALTH HISTORY

SACRAMENTO
EAR | NOSE | THROAT
FACIAL PLASTIC SURGERY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Patient's Last Name: ______________ First: ______________ Mi: ______________

Address: ______________ City: ______________ State: ________ Zip: ______________

Primary Phone: ______________ (☐ Home/☐ Cell) Patient's SSN: ______________ Email Address: ______________

Gender: ☐ Male ☐ Female Date of Birth: ______________ Marital Status: ☐ Single/ ☐ Married / ☐ Divorced / ☐ Widowed

Race: ______________ Ethnicity: ☐ Hispanic / ☐ Non-Hispanic / ☐ Decline to State

Preferred Language: ☐ English / ☐ Spanish / ☐ Other: ______________

Patient's Employer: ______________ Phone: ______________ Occupation: ______________

Full Time Student: ☐ Yes ☐ No Name of Parent/Guardian *(if under 18)*: ______________

Emergency Contact: ______________ Relationship to Patient: ______________ Phone: ______________

Name of Primary Care Physician: ______________ Name of Referring Physician: ______________

Pharmacy Preference (Include location): ______________

REASON FOR TODAY'S VISIT: ______________

Primary Ins.: ______________ Policy Holder Name: ______________ DOB: __________ SSN: ______________

Secondary Ins.: ______________ Policy Holder Name: ______________ DOB: __________ SSN: ______________

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage	How Often Taken

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

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATIONS:

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ Yes ☐ No

If yes, please list type of problems: ______________

____

List any surgeries you have had (including dates): ______________

Have you ever been hospitalized for non-surgical reasons?: ☐ Yes ☐ No

If yes, list reasons for hospitalizations: ______________

____

(Office Use): Height _______ Weight _______ B/P _______

Have you ever had the following immunizations? ***(Please circle yes or no)***

Flu Vaccine: ☐ Yes ☐ No

Date: ________________________

Pneumonia Vaccine: ☐ Yes ☐ No

Date: ________________________

Social History

Do you smoke? ☐ Yes ☐ No

If yes, answer the following questions.

1. How many cigarettes do you smoke per day? ________________________
2. How long have you been smoking? ________________________

Do you drink alcohol? ☐ Yes ☐ No

1. How many cigarettes do you smoke per day? ________________________
2. How long have you been smoking? ________________________

If yes, answer the following questions.

1. Have you ever felt like you should cut down on your drinking? ☐ Yes ☐ No
2. Have you ever been annoyed when people comment on your drinking? ☐ Yes ☐ No
3. Have you ever felt guilty or badly about your drinking? ☐ Yes ☐ No
4. Have you ever had an eye-opener first thing in the morning to steady your nerves? ☐ Yes ☐ No

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned, authorize payment of medical benefits to Sacramento Ear Nose and Throat Surgical Medical Group, Inc., for any services furnished the patient by the physician. I understand that my agreement with my insurance company is a separate agreement between myself and my insurance company and that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company, or their agent, information concerning health care, advice, treatment or supplies provided to the patient. This information will be used for the purpose of evaluating and administering claims of benefits.
I also understand that in the event I have no insurance coverage, I am responsible for all billed charges.

____ ________________________

Responsible Party's Signature Date

This document must be signed in the office.