MURFREESBORO MEDICAL CLINIC, P. A.
OTOLARYNGOLOGY DEPARTMENT

PATIENT HISTORY

MRN#_____
Provider #/Name_____

Name_____ Date of Birth_____ Date_____
Email Address_____
Purpose of visit_____
Referring physician_____
Primary Care Provider_____
Current Pharmacy _____

MEDICAL HISTORY *Please check all that apply:*

__arrhythmias	__hepatitis	__reflux	__cancer
__heart attack (myocardial infarction)	__hyperthyroidism	__peptic ulcer	__asthma
__congestive heart failure	__hypothyroidism	__emphysema	__stroke
__hypertension	__diabetes	__convulsive disorder	
__HIV/AIDS	__depression	__blood transfusion	

REVIEW OF SURGICAL HISTORY: *Please list any previous surgeries:*

1._____
2._____
3._____
4._____
5._____
6._____

MEDICATIONS: *Please list any medications & dosages you are taking on a regular basis, including over the counter. Also please indicate if you take aspirin or anti-inflammatory on a regular basis:*

1._____	2._____	3._____
4._____	5._____	6._____
7._____	8._____	9._____
10._____	11._____	12._____
13._____	14._____	15._____

DRUG ALLERGIES: *Please list medication that you are allergic*:

1._____
2._____
3._____

FAMILY HISTORY: Please list any illnesses found in blood relatives (mother, father, grandparents, brothers, sisters):

__Coronary Heart Disease	__Diabetes
__Hypertension (high blood pressure)	__Stroke
__Bleeding and/or Clotting Problem	__Cancer
__Problem with Anesthesia	

SOCIAL HISTORY:

Occupation: _____
Married_____Single_____Widowed_____Divorced_____
Tobacco: Yes____ No____ How much_____ Any Family Members Smoking at home (inside or outside) _____
Alcohol: Yes____ No____ Social ____ Heavy____
Recreational Drugs: Yes____ No____
Caffeine: Yes____ No____ Type_____ How much_____

REVIEW OF SYMPTOMS: *Please check all that apply:*

__Fever	__Chills	__Mouth Sores	__Headache
__Loss of Hearing	__Flushing	__Hoarseness	__Head Trauma
__Earache	__Night Sweats	__Cough	__Constipation
__Sore Throat	__Ringing Ears	__Phlegm in Throat	__Diarrhea
__Sinus Pain/Pressure	__Sneezing s	__Drip Down Throat	__Snoring
__Nasal Discharge	__Nasal Stuffiness	__Eyes Itch	__Enlarged Tonsils/Adenoids
__Feeling Tired	__Nosebleed	__Blurry Vision	__Ear Wax
__Sweating	__Recurrent Strep	__Eyes Watering __	__Sense of Smell Loss
__Weight Loss	__Difficulty Swallowing	__Seeing Double	__Sense of Taste Loss
__Weight Gain	__Lump in Throat	__Dizziness	__Nasal Fracture: _____
__Jaw Pain	__Nasal Pain	__Other: _____	