Glacier Ear Nose and Throat – In order to obtain a complete medical history, it is important for you to fill out this form. If the question does not apply, enter "n/a". This information is important for your doctor to review and it will be entered into your medical record.

Last Name:	First Name:	MI:	Preferred Name:
Date of Birth:	Height:	Weight:	Occupation:
Reason for visit:			
Referring Physician:		**Primary Care Physician:**	

Select your gender identity (select any that apply):

☐ Female ☐ Male ☐ Transgender Male-to-Female ☐ Transgender Female-to-Male
☐ Nonbinary ☐ Choose not to disclose ☐ Other:

Preferred Pronouns: ☐ He/him ☐ She/her ☐ They/them ☐ Other:

Select your race (select any that apply): ☐ American Indian ☐ Alaskan Native ☐ Native Hawaiian
☐ Pacific Islander ☐ Black or African American ☐ White (Not Hispanic/Latino)
☐ Decline to state ☐ Other:

Ethnicity: ☐ Hispanic or Latino ☐ Decline to state ☐ Other:

Do you have a **latex allergy**? ☐ Yes ☐ No

Do you have any history, or a diagnosis of, the following? (check any that apply)

Any type of cancer? ☐ Yes ☐ No What type of cancer and what is the status?_____
_____

High blood pressure ☐ Yes ☐ No Neurologic disorder ☐ Yes ☐ No Autoimmune disorder ☐ Yes ☐ No
Kidney disease ☐ Yes ☐ No Diabetes ☐ Yes ☐ No
Liver disease ☐ Yes ☐ No HIV positive ☐ Yes ☐ No

- Have you been diagnosed with an upper respiratory infection (URI) that did **NOT** result in an antibiotic being prescribed? ☐ Yes ☐ No
- Have you been diagnosed with Acute Otitis Externa (AKA swimmer's ear)? ☐ Yes ☐ No. Did you receive antimicrobial therapy? ☐ Yes ☐ No
- Have you been diagnosed with otitis media? ☐ Yes ☐ No. Did you receive antibiotics for the ear infection? ☐ Yes ☐ No
- Have you been diagnosed with and/or treated for adult sinusitis? ☐ Yes ☐ No. Did you have Amoxicillin prescribed? ☐ Yes ☐ No

Any history of **major medical or surgical treatment for your heart or lungs**? ☐ Yes ☐ No. If yes, please list them:

- Do you have any personal or family history of bleeding disorders? ☐ Yes (circle one): Personal/Family ☐ No
- Do you take any blood thinning medications? ☐ Yes ☐ No. If yes, why do you take the medication?
  ☐ Atrial fibrillation ☐ Blood Clot ☐ Heart or vascular stent ☐ Other:
- What blood thinning medications are you taking? ☐ Apixaban (Eliquis) ☐ Dabigatran (Pradaxa)
  ☐ Rivaroxaban (Xarelto) ☐ Warfarin ☐ Aspirin ☐ Not taking any ☐ Other:

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Surgeries and Hospitalizations:

Have you ever had any problems with anesthesia? ☐ Yes ☐ No. Please explain:_____

_____

Have you ever had a surgical site infection? ☐ Yes ☐ No. If yes, explain:_____

List any **past surgeries or major procedures** and the dates or estimate when they were performed:

_____

_____

_____

_____

_____

Have you received the following vaccines:

COVID-19 vaccine? ☐ Yes ☐ No Last year of vaccination:

Influenza vaccine? ☐ Yes ☐ No Last year of vaccination:

Pneumococcal vaccine? ☐ Yes ☐ No Last year of vaccination:

List the month and year (estimates are fine) of any recent diagnostic/Screening Tests:

Pap Smear: Colonoscopy: Sigmoidoscopy: Esophagoscopy: Mammography:

Current smoking status: ☐ Never smoked ☐ Former smoker ☐ Current smoker

Have you received tobacco cessation interventions by a physician? ☐ Yes ☐ No

Do you have any history of drug abuse? ☐ Yes ☐ No

Please list any medications you are currently taking:

Name:	Dosage:	How often do you take it?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any allergies you have to medications: **CHECK HERE IF YOU DO <u>NOT</u> HAVE ANY DRUG ALLERGIES** ☐

Name:	Type of reaction:
_____	_____
_____	_____

List your Pharmacy Preference: **City:**

Date:_____

Printed Patient Name:_____ Patient Signature:_____