CAROLYN J. AGRESTI, M.D.
EAR, NOSE AND THROAT, INC • HEARING AND BALANCE, LLC

PATIENT HISTORY

NAME			DOB
HEIGHT	WEIGHT	REASON FOR VISIT	

Medications (Please include any over-the-counter medications)

Name	Dosage (i.e. mg, etc.)	Frequency (Times per day)

Pharmacy

LOCAL PHARMACY NAME	**PHONE**
ADDRESS (INCLUDE CROSS STREET)	**CITY / STATE / ZIP**
MAIL ORDER COMPANY	

NAME	DOB

Past Medical History

Allergies	○ Yes	○ No	**HIV**	○ Yes	○ No	**Reflux/GERD/Heartburn**	○ Yes	○ No
Anemia	○ Yes	○ No	**Hypertension**	○ Yes	○ No	**Seizure Disorders**	○ Yes	○ No
Bleeding Disorders	○ Yes	○ No	**Immune Disease**	○ Yes	○ No	**Sinusitis**	○ Yes	○ No
Bowel Disorders	○ Yes	○ No	**Imbalance/Dizziness**	○ Yes	○ No	**Sleep Apnea**	○ Yes	○ No
Cancer	○ Yes	○ No	**Kidney Disease**	○ Yes	○ No	**Stomach Disorders/Ulcers**	○ Yes	○ No
Diabetes	○ Yes	○ No	**Liver Disease**	○ Yes	○ No	**Thyroid Disorders**	○ Yes	○ No
Glaucoma	○ Yes	○ No	**Lung Disease**	○ Yes	○ No	**Tinnitus/Ringing In Ears**	○ Yes	○ No
Headaches/Migraines	○ Yes	○ No	**Nasal Trauma**	○ Yes	○ No	**Tuberculosis**	○ Yes	○ No
Hearing Loss	○ Yes	○ No	**Nervous System**	○ Yes	○ No	○ **Other:**		
Heart/Cardiac	○ Yes	○ No	**Nose Bleeds**	○ Yes	○ No			
Hiatal Hernia	○ Yes	○ No	**Psychiatric Disorders**	○ Yes	○ No			

Have you ever had a colonoscopy?	○ Yes	○ No	**If yes, when was your last colonoscopy?**	(mo.)	(yr.)
Have you ever had a mammogram?	○ Yes	○ No	**If yes, when was your last mammogram?**	(mo.)	(yr.)
Have you ever had a flu shot?	○ Yes	○ No	**If yes, when was your last flu shot?**	(mo.)	(yr.)
Have you ever had a Pnemovax shot?	○ Yes	○ No	**If yes, when was your last Pnemovax shot?**	(mo.)	(yr.)

Please list any previous surgeries:

Social History

Do you smoke?:	○ Yes	○ No	**If yes, how many pack per day?:**		
Have you quit smoking?	○ Yes	○ No	**If yes, when did you quit?:**	**Packs per day:**	
Do you drink alcohol?	○ Yes	○ No	**If yes, how many drinks?:**	○ **Per day**	○ **week** ○ **month**
How many caffeinated beverages do you drink per day?:					
How many glasses of water do you drink per day?:					
Do you smoke marijuana?	○ Yes	○ No	**Use any other drugs?** ○ Yes ○ No	**If yes, what?:**	

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NAME	DOB

Allergies To Medication

○ Yes ○ No	**If yes, please list any medications you are allergic to below:**
Name:	**Type of reaction:** ○ Rash ○ Lip/Throat Swelling ○ Other:
Name:	**Type of reaction:** ○ Rash ○ Lip/Throat Swelling ○ Other:
Name:	**Type of reaction:** ○ Rash ○ Lip/Throat Swelling ○ Other:

Family History

Allergies	○ Yes ○ No	**Family Member:** ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Maternal Grandmother ☐ Maternal Grandfather ☐ Paternal Grandmother ☐ Paternal Grandfather
Diabetes	○ Yes ○ No	**Family Member:** ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Maternal Grandmother ☐ Maternal Grandfather ☐ Paternal Grandmother ☐ Paternal Grandfather
Cancer	○ Yes ○ No	**Family Member:** ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Maternal Grandmother ☐ Maternal Grandfather ☐ Paternal Grandmother ☐ Paternal Grandfather
Heart/Cardiac	○ Yes ○ No	**Family Member:** ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Maternal Grandmother ☐ Maternal Grandfather ☐ Paternal Grandmother ☐ Paternal Grandfather
Sleep Apnea	○ Yes ○ No	**Family Member:** ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Maternal Grandmother ☐ Maternal Grandfather ☐ Paternal Grandmother ☐ Paternal Grandfather
Thyroid Disorders	○ Yes ○ No	**Family Member:** ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Maternal Grandmother ☐ Maternal Grandfather ☐ Paternal Grandmother ☐ Paternal Grandfather

By signing, I attest that all the information above is up to date and correct to the best of my knowledge.

PATIENT SIGNATURE	DATE