JAMES G. WILLIAMS, M.D.
COVINA EAR, NOSE & THROAT MEDICAL GROUP, INC.

Name_____ **Weight** _____ **Height** _____

Reason for today's visit?_____

_____

Medical History: Have you ever had/been treated for:

No	Yes		No	Yes		No	Yes	
☐	☐	Diabetes	☐	☐	Headaches	☐	☐	Neck Problems
☐	☐	Asthma	☐	☐	Ear Ringing	☐	☐	High Blood Pressure
☐	☐	Blurred Vision	☐	☐	Excessive Bleeding	☐	☐	Nose Bleeds
☐	☐	Stroke	☐	☐	Tuberculosis	☐	☐	Cancer
☐	☐	Heart Problems	☐	☐	Grinding Teeth	☐	☐	Sinus Problems
☐	☐	Tonsillitis	☐	☐	Mouth Sores	☐	☐	Thyroid Disorder
☐	☐	Psychiatric Disorders	☐	☐	Seizures	☐	☐	Lung Disorders

Have you had any previous infections? ☐ Yes ☐ No

Illnesses/Explanations:_____

_____

Have you had any surgery?

Had Surgery for:	Date of Surgery:	Complications of:
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any family member(parents, siblings, grandparents) who have had:

Diabetes_____ Cancer(Type)_____

Stroke_____ High Blood Pressure_____

Heart Disease_____ Other_____

Are you taking anticoagulants/blood thinners daily (ie. Aspirin) ☐ No ☐ Yes

Are you currently taking any medications? ☐ No ☐ Yes

If numerous please attach list.

Medication	For what Condition	For how long?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you currently taking any over the counter medications or vitamins (Ibuprofen,Advil, Motrin, Excedrin, Aleve, Aspirin, Fish Oils, Vitamin E, Glucosamine/Chondroitin)?

☐ No ☐ Yes (specify)_____

Do you smoke cigarettes/cigars? ☐ No ☐ Yes Packs(amt)/day _____ Years_____

Did you ever use tobacco? ☐ No ☐ Yes How long ago?_____

Would you like info on smoking cessation? ☐ No ☐ Yes

Alcoholic beverages? (Check one)

☐ None ☐ Rarely ☐ Moderately(weekly) ☐ Daily ☐ Quit

Recreational drugs? (Check one)

☐ None ☐ Rarely ☐ Moderately(weekly) ☐ Daily ☐ Quit

Food Allergies: ☐ No ☐ Yes (Please specify) _____

Allergies: Is there a history of allergic reaction or sickness following injection, oral or topical administration of:

(Check box that applies)	No	Yes		No	Yes
Penicillin	☐	☐	Aspirin	☐	☐
Sulfa drugs	☐	☐	Tylenol	☐	☐
Other antibiotics(list below)	☐	☐	Advil, Aleve, or Motrin(circle)	☐	☐
Morphine	☐	☐	Other pain remedies (list below)	☐	☐
Codeine	☐	☐	Adhesive tape	☐	☐
Demerol	☐	☐	Iodine or Merthiolate	☐	☐
Other narcotics (list below)	☐	☐	Any other drugs or medications	☐	☐

List any other allergies: _____

Immunizations:

Tetanus ☐ No ☐ Yes,; Flu Vaccine(past year) ☐ No ☐ Yes: Pneumonia Vaccine (past year) ☐ No ☐ Yes

Other: Please provide any relevant details or additional conditions:_____

_____