Crystal Community ENT • Dr. Denis Grillo

Dear patient it has been over a year since we updated your health history.
Please fill out as completely as possible.

Name:_____DOB: _____ Date:_____
Primary Care Doctor: _____
Name and town of Pharmacy :_____
* All prescriptions will be emailed to pharmacy above unless you request a written prescription

Your Last visit was _____ since that visit have you had :
Any new procedures or surgeries? ☐ Yes : see list below & anesthesia ? ☐ No new surgeries

_____ _____
_____ _____

Any new reactions to anesthesia? ☐ Yes : _____ ☐ No
Do you see a Cardiologist? ☐ Yes : Dr. _____ ☐ No

Have you been Diagnosed with any new Medical Conditions? (i.e. Diabetes, Blood pressure)
☐ Yes : _____ ☐ No
_____

Social History Changes: **☐ Yes: see changes below ☐ No changes in Social History**

Do you smoke tobacco products?	YES	NO		
If **YES** what products do you use?	Cigarettes /Cigars / Pipe		_____# Packs per day	_____Years
Did you ever smoke and quit?	YES	NO	_____# Years Ago _____	# Packs per day _____Years
Do you chew tobacco or dip?	YES	NO	_____ Years	Quit, how long? _____
Do you drink alcoholic beverages?	YES	NO	Occasionally _____	Frequently _____
Do you use or have you ever used street drugs?	YES	NO	What? _____	How long? _____
Do you drink caffeine products?	YES	NO	What? _____	# Per day _____
Does anyone in the house smoke?	YES	NO		

Please list all new medication:
Medication Name & Strength/ Dose/ Why you take

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Drug Allergies:
☐ Yes see list below
☐ No new drug allergies

_____
_____
_____
_____
_____
_____
_____

Dr. Initial	Date	Dr. Initial	Date