ISLAND ENT / SLEEP DISORDER CENTER OF KEY WEST

1438 Kennedy Drive, Key West, FL 33040
Tel: 305-292-2259 Fax: 305-407-9991

Medical History

Date:_____/_____/_____Name:_____

Age:_____ Date of Birth:___/____/____ Weight:_____ Height:_____

_____Referred by Dr. _____

_____ Patient (Name) _____

How did you hear about us?

_____ Internet _____ Yellow Pages _____ Magazine Ad

_____ Radio _____ Newspaper

This is a confidential record of your medical history and will be kept in this office. Information will not be released to any person without authorization.

All Current Medications & Doses / Non Prescription Drugs / Vitamins / Herbal Supplements

1._____ 3. _____ 5._____

2._____ 4. _____ 6._____

Symptoms / problems for which you are being seen <u>today</u>:

1._____ 3. _____

2._____ 4. _____

Please check mark any other symptoms you are having:

Hearing Problems	**_____**	**Difficult Swallowing**	**_____**	**Insomnia**	**_____**
Chest Pain	**_____**	**Frequent Indigestion**	**_____**	**Fatigue**	**_____**
Palpitation	**_____**	**Headaches**	**_____**	**Snoring**	**_____**
Heart Burn	**_____**	**Pneumonia**	**_____**		
Numbness/Tingling	**_____**	**Shortness of Breath**	**_____**		

Medical History

Do you currently have or ever had any of these illnesses? (Please Check Answers)

Hypertension	**_____**	**Diabetes**	**_____**	**Bronchitis**	**_____**	**Psychiatric**	**_____**
Asthma	**_____**	**T.B.**	**_____**	**Nerve Problem**	**_____**	**Bowel Disease**	**_____**
Hepatitis	**_____**	**H.I.V.**	**_____**	**Muscle Problem**	**_____**	**Stroke**	**_____**
Seizures	**_____**	**Cancer**	**_____**	**Skin Problems**	**_____**	**Arthritis**	**_____**
Osteoporosis	**_____**	**Heart**	**_____**	**Vision Problems**	**_____**		

Do you currently have chicken pox or shingles? _____Yes _____No

To what medications are you allergic?_____

MEDICAL/SURGICAL HISTORY: List Serious Illnesses, Injuries, Operations, Hospitalizations and the year these occurred.

Problem **Year**

1. _____

2. _____

3. _____

4. _____

5._____

6. _____

Do you use alcohol? Y N (Circle One) How much do you drink/day?_____

How long have you used tobacco?_____How much?_____How often?_____

Family History

RELATIVE AGE, IF LIVING HEALTH AGE AT DEATH & CAUSE
Mother:_____
Father:_____
Brothers/ Sisters:_____
_____
Children:_____
_____

Thank you!