Brian J. McCool, M.D.

McCOOL & BHUTA

Ear Nose and Throat Specialists

Tarika Bhuta, M.D.

HEALTH HISTORY

Name: _____

Height: _____ Weight: _____ Age: _____

Referred by: _____

Chief Complaint (Reason for your visit): _____

_____

REVIEW OF ORGAN SYSTEMS

(If you have no symptoms in a certain area please leave blank. If you do have symptoms, please explain in the space provided.)

General symptoms (fever, weight loss, etc.)

Eyes: _____

Ears, Nose, Mouth & Throat: _____

_____

_____

_____

Heart: _____

Lungs: _____

Stomach and Intestines (reflux, heartburn): _____

Bladder & Urinary System: _____

Muscles & Bones: _____

Skin: _____

Neurological (Brain & Nervous System): _____

Psychiatric (Nerves, anxiety, depression): _____

Endocrine (Thyroid, Hormones,Cholesterol): _____

Hematologic (Bleeding Disorders): _____

Allergic/Immunologic: _____

_____

_____

_____

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PAST MEDICAL HISTORY

Major Illnesses: High Blood Pressure _____ Diabetes_____ Heart Disease _____

Other:_____

Surgeries: _____

_____

Medications you are currently taking: _____

_____

_____

_____

Drug allergies: _____

_____

_____

FAMILY HISTORY

(Please circle any of the following severe illnesses that may run in your family and list the family member involved: M-mother, F-father, S-sibling, GP-grandparent)

High Blood Pressure	M	F	S	GP	Cancer	M	F	S	GP
Heart Disease	M	F	S	GP	Bleeding Disorder	M	F	S	GP
Diabetes	M	F	S	GP	Anesthesia Complications	M	S	F	GP

Other: _____

SOCIAL HISTORY

Occupation: _____

Tobacco Use: Packs per day:_____ How Many Years:_____

Alcohol: Type:_____ Amount Per Week:_____

_____

Patient Signature Date

PHYSICIAN REVIEW

I have reviewed and confirmed the information noted above, and have annotated the records as needed

_____MD _____

Date

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