STARK ENT, ALLERGY & SINUS CENTER

Medication & Surgery History

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. Please fill out every item. It is important for your doctor to know you have carefully reviewed every area of this form.

Patient's Name:_____ **Date of Birth**_____

Height: _____ **Weight:**_____

Reason for Today's Visit: _____

Please list any Medications you are currently taking:

Name Of Medication	Dosage	How often Taken

Are you Allergic to any medications? YES / NO **If yes, please list below:**

Name Of Medication	Reaction

Surgeries and Hospitalizations
Have you ever had any problems with anesthesia (being numbed or put to sleep)? Yes / No
If yes, please explain: _____
_____

List any surgeries you have had (including dates): _____
_____

Have you ever been hospitalized for nonsurgical reasons? Yes / No
If yes, list reasons for hospitalizations: _____
_____

Current or most recent occupation: _____