CANYON VIEW
EAR, NOSE & THROAT

Patient Medical History and Authorizations

Date: _____

Patient's Name: _____ Date of Birth: _____

Weight: _____ Height: _____

For Office Use Only:
HR: _____ BP: _____ %O2: _____

What is the reason for your visit today? _____

Past Medical History: Have you ever experienced any of the following?

- ○ Allergies
- ○ Anemia
- ○ Anesthesia Reaction
- ○ Arthritis
- ○ Asthma
- ○ Back Pain
- ○ Bleeding Disorders
- ○ Cancer
- ○ Chest Pain
- ○ Diabetes
- ○ Ear, Nose, and/or Throat problems
- ○ Immunological Disorders
- ○ Kidney Problems
- ○ Migraines
- ○ Seizure Disorders
- ○ Shortness of Breath
- ○ Sinus Conditions
- ○ Sleep Apnea
- ○ Stroke
- ○ Substance Abuse
- ○ Thyroid Disorders

Surgical History: Please list any surgeries you have had, indicating the year in which they occurred: _____

_____

_____

Family History: Please indicate if any of your immediate relatives have experienced any of the following:

	Mother	Father	Siblings	Grandparents
Alcoholism				
Anesthesia Problems				
Asthma				
Bleeding Disorders				
Cancer				
Cardiovascular Disease				
Headaches/Migraines				
Hypertension				
Kidney Disease				
Liver Problems				
Seizures				
Sleep Apnea				
Stroke				
Substance Abuse				

Social History:

Yes No Do you drink alcohol? If yes, how much? _____
Yes No Do you drink caffeine? If yes, how much? _____
Yes No Are you currently married?
Yes No Do you have pets in your home?
Yes No Do you currently use tobacco? If yes, do you smoke or chew? How much? _____
Yes No Have you ever used tobacco in the past? If yes, when did you quit? _____
Yes No Does anyone in your household smoke?
Yes No Have you ever used illegal drugs or abused prescription drugs? If yes, when? _____
Yes No For infants only, is the child in daycare?
Yes No For infants only, does the child drink from a bottle?
Yes No For infants only, does the child use a pacifier?

Medications: Please **list any and all** medications that you are currently taking: _____

_____

_____

Allergies: Are you allergic to any of the following?

Yes No Foods (please list): _____
Yes No Medications (please list): _____
Yes No Pet Dander
Yes No Latex
Yes No Pollen/Seasonal
Yes No Other:

Review of Symptoms: Which symptoms are you currently experiencing?

○ Fever	○ Sleep Apnea	○ Bleeding Disorders
○ Vision Changes	○ Snoring	○ Kidney Problems
○ Dizziness	○ Sore Throat	○ Back Pain
○ Bloody Nose	○ Tinnitus	○ Dermatitis
○ Headache	○ Chest Pain	○ Rash
○ Hearing Loss	○ Hypertension	○ Seizures
○ Ear Infection	○ Asthma	○ Thyroid Disease
○ Ear Pain	○ Cough	○ Allergies
○ Sinus Congestion	○ Shortness of Breath	○ Other: _____

CONSENT FOR TREATMENT: By signing below, I hereby authorize Dr. Robert Pearson to perform diagnostic, medical and/or surgical procedures on me and to administer medication to me as may be necessary for proper health care.
AUTHORIZATION TO RELEASE INFORMATION: By signing below, I hereby authorize Dr. Robert Pearson to release any medical information necessary for medical reasons or in processing claims for insurance benefits and/or applications for final benefits, including but not limited to Rehabilitation Services, Social Security Benefits and Worker's Compensation Benefits. Further, I hereby authorize Canyon View Ear, Nose & Throat to release any medical information or test results to myself or my answering machine, voice mail, email address or to any of the following persons:

Name:_____ Relation:_____ Phone #: _____

Name:_____ Relation:_____ Phone #: _____

AUTHORIZATION TO OBTAIN MEDICAL RECORDS AND INFORMATION: By signing below, I hereby authorize the release of any and all of my medical information to Dr. Robert Pearson from any physicians who have provided treatment to me, made diagnoses and/or performed procedures for the present or any related conditions, including any X-rays and laboratory results.

PRIVACY PRACTICES ACKNOWLEDGEMENT: By signing below, I acknowledge that I have read and review the Health Insurance Portability and Accountability Act (HIPPA) Privacy and Compliance Notice that has been provided to me by this office.

Patient/Responsible Party Signature:_____ **Date:** _____

Patient Name (Please Print):_____ **Date:** _____

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