

**Mark Aferzon, M.D., F.A.C.S.**  
**Ear, Nose & Throat Specialist**

**Patient History Form**

Date of visit: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Reason for your visit here: \_\_\_\_\_

List medical conditions for which you are under the care of a healthcare provider: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you had any surgical procedures or hospitalizations in the past? **Yes No (Please circle)** please list:

\_\_\_\_\_

\_\_\_\_\_

Please list all medications you take, including dosages (or provide a list):

\_\_\_\_\_

\_\_\_\_\_

Do you have any allergies to medications? **Yes No (Please circle)** If yes please list: \_\_\_\_\_

\_\_\_\_\_

Have you ever had a reaction to anesthesia? **Yes No** If yes explain: \_\_\_\_\_

**Family History:** *(Please circle any that apply to Blood relatives; no circle would indicate a negative response)*

Diabetes High blood pressure Heart disease Bleeding problems Allergies Cancer Asthma

Other: \_\_\_\_\_

**Social History:**

What is your occupation? \_\_\_\_\_ Marital status: S M D W

Do you smoke? Yes/No If yes for how long \_\_\_\_\_ How much: \_\_\_\_\_ Do you drink alcohol? Yes/No If yes how often \_\_\_\_\_

**Review of Systems:** *(Please circle yes or no)*

Fever	Yes No	Malaise	Yes No	Weight Change	Yes No	Itching	Yes No
Rash	Yes No	Hearing Loss	Yes No	Ringling	Yes No	Nose Bleeds	Yes No
Nasal Congestion	Yes No	Allergies	Yes No	Hoarseness	Yes No	Neck Mass	Yes No
Neck Pain	Yes No	Cough	Yes No	Snoring	Yes No	Asthma	Yes No
Chest Pain	Yes No	Palpitations	Yes No	Difficulty Swallowing	Yes No	Heartburn	Yes No
Arthritis	Yes No	Headaches	Yes No	Dizziness	Yes No	Depression	Yes No
Anxiety	Yes No	Thyroid Problems	Yes No	Diabetes	Yes No	Anemia	Yes No
Excessive Bleeding	Yes No	Easy Bruising	Yes No				

Other symptoms not listed: \_\_\_\_\_

Patient Signature: \_\_\_\_\_