

Petoskey Ear Nose & Throat Specialists
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Howard J. Beck, M.D.

Kevin L. Gietzen, D.O.

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Name: _____ **Birth Date:** / / **Date:** / /

PATIENT HISTORY

Have you ever had or do you have...

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Problem | |
| <input type="checkbox"/> Angina/Heart Attack | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Lung Problem | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Mental Illness | |
| <input type="checkbox"/> Asthma/Hay Fever | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Headaches | <input type="checkbox"/> Thyroid Problem | |
| <input type="checkbox"/> Bladder Disease | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Venereal Disease | |

Drug Allergies

Medications-Dose-Frequency

Surgeries and Injuries

FAMILY HISTORY

Has anyone in your family had...

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Problem | |
| <input type="checkbox"/> Angina/Heart Attack | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Lung Problem | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Mental Illness | |
| <input type="checkbox"/> Asthma/Hay Fever | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Headaches | <input type="checkbox"/> Thyroid Problem | |
| <input type="checkbox"/> Bladder Disease | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Venereal Disease | |

SOCIAL HISTORY

Do you...

- | | | | |
|---|--------------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Exercise Regularly | <input type="checkbox"/> Use Alcohol | <input type="checkbox"/> Use Tobacco | <input type="checkbox"/> Use Drugs |
| Type: _____ | Beer/Wine/Liquor | Cigarettes/Cigars/Pipe | Marijuana/Heroin |
| How Often: _____ | How Often: _____ | Snuff/Chew Tobacco | Cocaine/LSD/Crack |

Occupation: _____

Marital Status: _____

FOR OFFICE USE ONLY

Reviewed/Updated	____/____/____; ____	____/____/____; ____	____/____/____; ____
____/____/____; ____	____/____/____; ____	____/____/____; ____	____/____/____; ____
____/____/____; ____	____/____/____; ____	____/____/____; ____	____/____/____; ____

