Dr. John Kveton's PATIENT HISTORY FORM

Date _____

Name _____ Date of Birth _____

Allergies to Medications (with reactions)

_____

_____

_____

Past Medical History (check only if it applies to you)

	Yes	No		Yes	No
Diabetes			Bleeding disorder		
Hypertension			Allergy problems		
Heart Disease			Kidney problems		
Asthma			Anesthesia problems		
Other (please explain):			Thyroid problem		
			Cholesterol problem		

Surgical History (procedure and date)

_____

_____

Medication List (name and dose if known)

_____

_____

_____

Social History

Do you use tobacco? O Yes O No Have you used tobacco in the past? O Yes O No

Do you drink alcohol? O Yes O No Do you have pets? O Yes O No

Occupation _____

Most recent: Colonoscopy _____ Pneumonia shot _____ Mammogram _____

Dr. John Kveton's PATIENT HISTORY FORM

Family History

	Yes	No	Relative(s)
Hearing problems			
Allergies			
Diabetes			
Cancer			
Bleeding disorder			
Anesthesia problems			
Heart problems			

Review of Systems

Category	System	Yes	System	Yes
General	Fatigue		Weight change	
Neuro	Headaches		Weakness	
GI	Difficulty Swallowing		Reflux – heartburn	
Allergy	Environmental allergy		Sneezing fits	
Eyes	Eye pain		Vision change	
ENT	Throat sore		Snoring or apnea	
Respiratory	Wheezing		Shortness of breath	
Hem/lym	Swollen glands		Bleeding problems	
Skin	Rash		Hives	
Psych	Depression		Anxiety	
Endocrine	Cold intolerance		Excessive sweating	
Heart	Chest pain		Palpitations	
Urinary	Blood in urine		Frequent urination	

Signature _____ Date _____

Ear Nose & Throat
MEDICAL AND SURGICAL GROUP, LLC