THE BARRANCO CLINIC
Otolaryngology-Head & Neck Surgery
Allergy • Facial Plastic & Reconstructive Surgery

160 East Lake Howard Drive • Winter Haven, Florida 33881
Sebring Lakeland Lake Wales Haines City Clermont Ocoee
Phone: (863) 299-1251 • Fax: (863) 299-7666

MEDICAL HISTORY

PATIENT NAME _____ Today's Date _____ / _____ / _____

Date of Birth _____ / _____ / _____ Daytime Phone Number: (____) _____ Height: _____ Weight: _____ Sex: M F

Referred By: _____ Phone Number: (____) _____ Primary Care Doctor: _____

PAST MEDICAL HISTORY

	YES	NO
Asthma		
Hayfever (Allergic Rhinitis)		
Allergy Injections		
History of Allergy Testing		
Hypertension/Heart Disease		
Diabetes		
Cancer		
Acid or GI Reflux		
Anemia/Bleeding Disorders		
Thyroid Disease		
Sleep Apnea		
Skin Disease		
Hypercholesterol		
Hyperlipedemia		

REVIEW OF SYSTEMS
Have you recently had or do you have any problem with:

EARS	YES	NO
Hearing Loss		
Pain		
Pressure		
Ringing		
Vertigo or Dizziness		
Noise Exposure		
Frequent Infections		
Discharge		

Any Other Medical Issues?

_____

_____

_____

REVIEW OF SYSTEMS (cont.)
Have you recently had or do you have any problem with:

NOSE	YES	NO
Obstruction		
Discharge		
Post Nasal Drip (PND)		
Bleeding		
Snoring		
Changes in Sense of Smell		
THROAT / LARYNX		
Difficulty Swallowing		
Frequent Infections		
Soreness		
Frequent Clearing		
Voice Changes		
Spitting Up Blood		
Changes in Sense of Taste		
OTHER		
Shortness of Breath (SOB)		
Wheezing		
Eyes Problems or Twitching		
Facial Numbness		
Headaches		
Arm/Leg Weakness		
Weight Loss		

FAMILY HISTORY
PLEASE CHECK ANY THAT APPLY or CIRCLE UNKNOWN

	PARENTAL	SIBLING
Heart Disease		
Hypertension		
Diabetes		
Hearing Loss		
Asthma		
Cancer Type _____		
Bleeding Disorders		
Allergies		

SOCIAL HISTORY

Do you use Tobacco? _____ No _____ Yes

Are you a Former Tobacco User? ____ No ____ Yes

Date Quit: _____

Do you drink Coffee? ___ No____ Yes ____# cups per day

Do you drink Alcohol? ___ No ___ Yes ____# drinks per day

Do you use Recreational Drugs?_____ No ____ Yes

ARE YOU ALLERGIC TO ANY MEDICATIONS? PLEASE LIST BELOW AND LIST REACTION.

MEDICATION	REACTION
1.	
2.	
3.	
4.	

Have you ever had an anaphylaxis reaction? _____ No _____ Yes

REVIEWED AND UPDATED BY PATIENT: Date: _____/_____/_____

Date: ____/____/____ Date: ____/____/____ Date: ____/____/____

Date: ____/____/____ Date: ____/____/____ Date: ____/____/____

PATIENT NAME:_____ Today's Date:_____

PLEASE LIST ALL MEDICATIONS

List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion.

MEDICATION	DOSAGE	WHAT IS THE DIAGNOSIS FOR THIS MEDICATION?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
If you need additional space, talk with the Medical Assistant once you have been called back to a room.		**Check here if additional page(s) of medicine list is attached [ ]**

Pharmacy_____ **Phone:** (_____)_____

OTHER HISTORY: MUST BE COMPLETED BY PATIENT

HAVE YOU?	YES	NO	HAVE YOU RECEIVED?	YES	NO
Had a Hip Replacement			Pneumonia Vaccine (ever)		
Had a Knee Replacement			Influenza Vaccine		
Fallen in last year					
If yes, Fallen 2 or more times or with injury					

PAST SURGICAL HISTORY

OPERATION	DATE	OPERATION	DATE:
1.		5.	
2.		6.	
3,		7.	
4.		8.	

Please use the space below for any additional medical history not included on the front.

Office Use Only: Reviewed and entered by:_____ **Date:** _____ / _____ / _____