TODD E. SAMUELSON M.D.
EAR NOSE & THROAT SURGEON
Texas Health Care, P.L.L.C.

Patient Medical Information *Date:*

Patient Name: _____

Birth Date: _____ Age: _____ Sex: M / F HT: _____ WT: _____

List any allergies to medications and/or food: _____

Briefly describe your present problem and how long it has caused you problems:

_____

Prior Medical History *If these categories are marked, please specify below*

___ Asthma
___ Arthritis
___ Stroke
___ Tuberculosis
___ HIV/AIDS
___ Seizures
___ Diabetes
___ Sleep Apnea
___ Glaucoma/Cataracts
___ Dementia
___ Anesthesia Problems
___ Genetic Disorders
___ Reflux
___ Depression
___ Anxiety
___ COPD/Lung Disease
___ Migraines
___ High Blood Pressure
___ High Cholesterol
___ Heart Attack/Heart Disease
___ Cancer (specify) _____
___ Spine Disorders (specify) _____
___ Thyroid Disorder (specify) _____
___ Bleeding Blood Disorder (specify) _____
___ Other/Not Listed _____

Do you drink alcohol? Y / N How much daily? _____ Caffeine drinks? Y / N How many daily? _____
Do you smoke? Y / N How much? _____ Type? _____ Quit? Y / N How? _____ Age Began? _____

Medications

Current Medications: _____

Preferred Pharmacy: _____

List all prior sugeries: _____

Family History

Cancer Y / N Diabetes Y / N High Blood Pressure Y / N Heart Disease Y / N Problems not listed? _____

Family Member _____ Age _____ Deceased Y / N What Type? _____

Signature: *Date:*