Head and Neck Specialty Group of New Hampshire

PATIENT UPDATED HISTORY

THIS FORM MUST BE COMPLETED IN FULL IF YOU ARE SEEING A PROVIDER TODAY.
The information on this form is necessary for providing you the very best care.

PATIENT NAME: _____

PATIENT SIGNATURE: _____

TODAY'S DATE: _____/_____/_____ **NURSE**: _____

CURRENT PRIMARY CARE PHYSICIAN: _____

CURRENT MEDICATION LIST: _____

_____

_____

ALLERGIES (to Medications & Latex): _____

_____

_____

SOCIAL OR FAMILY HISTORY PERTINENT TO PRESENT ILLNESS: _____

_____

_____

ANY NEW ILLNESS OR OPERATIONS: _____

_____

RECENTLY FINISHED MEDICATIONS: _____

_____

DO YOU USE TOBACCO: Yes ( ) No ( ) How much: _____

DO YOU CONSUME ALCOHOL: Yes ( ) No ( ) How much:_____

TODAY'S PRESENTING COMPLAINT: _____

_____

_____

PLEASE HAND TO RECEPTIONIST UPON ARRIVAL