Benjamin F. Asher, M.D.
RESTORATIVE ENT

MEDICAL HISTORY

Please use reverse side if you need more room.

CHIEF COMPLAINT:
What are your main complaints? State the nature and duration of the symptoms.

MEDICAL HISTORY:
Please list any medical problems (i.e.; heart disease, diabetes, high blood pressure, etc):

Do you have asthma? Yes _____ No_____

Do you have environmental allergies? Yes______No______What? ___________________

MEDICATION/SUPPLEMENTS/HERBAL PREPARATION:
Please list all medicines, both prescribed by a physician and over the counter that you are currently taking. Please include all supplements: vitamins, minerals, herbs, homeopathic remedies, etc.

MEDICATION ALLERGY AND INTOLERANCE:
List medications or supplements you are allergic to or which cause unpleasant side effects.

SURGICAL HISTORY:
Please list all operations and surgeries.

For Women: Are you pregnant? Yes___ No____ Uncertain____

FAMILY HISTORY:

Please describe any medical conditions and illnesses that run in your family.

Do you or does anyone in your family have a bleeding disorder? Yes____ No____

ALTERNATIVE MEDICAL HISTORY:

Please list alternative therapies that you currently use or have used (chiropractic, acupuncture, etc.

SOCIAL HISTORY:

Do you smoke cigarettes: Yes____ No____ How much?_______________

How long have you been smoking?_____________________

Do you drink alcohol: Yes____ No____ How much?_______________

How often?____

Type of alcohol: _____________________________________

Do you use drugs: Yes____ No____

MENTAL/EMOTIONAL:

How would you describe your stress level: Low____ Medium____ High____

Please list some of the major stressors in your life:

Please explain how you handle stress and what you do to relax: