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NEW YORK
SLEEP, SINUS & THYROID SURGERY CENTER

EDWARD J. SHIN M.D.

CONFIDENTIAL PATIENT HEALTH HISTORY

Today's Date:_____

Patient's Name:_____ Date of Birth: _____

MEDICAL HISTORY - CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

- ☐ Anemia
- ☐ Athritis, Rheumatism
- ☐ Asthma
- ☐ Back Problem
- ☐ Blood Disorders
- ☐ Cancer (site): _____
- ☐ Chemotherapy
- ☐ Cough, Persistant
- ☐ Cough with Bloody Sputum
- ☐ Dizziness
- ☐ Drug Dependency
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Problems - Describe: _____
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pace Maker
- ☐ Pyschiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Swelling of feet or ankles
- ☐ Thyroid Problems
- ☐ Tobacco / Cigarette Habit
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Others: _____

Have you ever had any serious illness or operations? Yes No If yes, describe:_____

Have you ever had a blood transfusion? Yes, date:_____No

List any medications you are currently taking:_____

_____

_____

Pharmacy Name:_____

Phone Number:_____

Allergies:

- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other_____

_____

Describe Reactions:_____

The above information is accurate and complete to the best of my knowledge. I will not hold my physician or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature:_____ **Date:**_____