



# 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**