

**Nina J. Lee-Tall, M.D, Inc.**

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**MEDICAL HISTORY FORM**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Do you currently have, or history of:**

Ear disease: \_\_\_\_\_

Nose/Sinus disease: \_\_\_\_\_

Throat/Mouth disease: \_\_\_\_\_

**Do you currently have, or history of:**

- |  |                                    |   |
|--|------------------------------------|---|
| <input type="checkbox"/> Seizure             | <input type="checkbox"/> Asthma    | <input type="checkbox"/> Major trauma: type _____     |
| <input type="checkbox"/> Heart attack        | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Cancer: type _____           |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke    | <input type="checkbox"/> Lung disease: type _____     |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Glaucoma  | <input type="checkbox"/> Heart disease: type _____    |
| <input type="checkbox"/> Autoimmune disease  |                                    | <input type="checkbox"/> Thyroid disease: type _____  |
| <input type="checkbox"/> Bleeding disorder   |                                    | <input type="checkbox"/> Severe allergies: type _____ |
| <input type="checkbox"/> Liver disease       |                                    | <input type="checkbox"/> Kidney disease               |

**Please note any medical problems you have been treated for, not listed above:**

\_\_\_\_\_  
\_\_\_\_\_

**Past surgical history: (Please list your operations and year performed)**

\_\_\_\_\_  
\_\_\_\_\_

**Medications you are currently taking (prescription or over the counter):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies to medications:**

**Family history of medical problems:**

\_\_\_\_\_  
\_\_\_\_\_

**Do you have currently or a history of:**

- |  |                  |                      |
|--|------------------|----------------------|
| <input type="checkbox"/> Smoking/tobacco use | Amount/day _____ | If quit, date: _____ |
| <input type="checkbox"/> Alcohol use         | Amount/day _____ | If quit, date: _____ |
| <input type="checkbox"/> Drug use            | Amount/day _____ | If quit, date: _____ |

**Patient/Guardian signature:** \_\_\_\_\_