# PATIENT HISTORY QUESTIONNAIRE

**Atlantic ENT LLC**
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**32931-3513**
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Name: _____ Date: _____

Date of Birth: _____

Main Complaint: _____

_____

_____

When did you first notice these symptoms: (mo/yr) _____

_____

Have you seen any other physician(s) for these problems? _____

If so, who? _____

_____

Have you taken any medication for these problems? _____ If so, what? _____

_____

_____

_____

_____

Does anything make your symptoms better: _____

_____

or worse: _____

_____

Any other contributing medical history? _____

_____

_____

_____

_____

_____

_____