

ENT PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcomed to a copy of the report if you wish.

Full Name _____ **Appointment Date** _____ **HT:** _____ **WT:** _____

SSN# _____ **Male** **Female** **Date of Birth** _____

Pharmacy Preference (include location) _____

Name of Primary Care Physician _____ **Name of Referring Physician** _____

Are you taking ANY kind of medication now? (This includes prescription, over-the-counter or herbal medications)

No Yes *If yes, please list below include dosages.*

Medication Name	Dosage	How often taken

ARE YOU ALLERGIC TO ANY MEDICATIONS? No Yes *If yes, please list below.*

Name of Medication	Type of Reaction

Are you allergic to any type of food? No Yes *If yes, what reaction do you have?* _____

Are you allergic to any non-medical things such as latex, tape, metal or contrast dye? No Yes latex tape metal

Have you ever been DIAGNOSED with any of the following problems?

Cancer (type) _____ No Yes

Head and Face:

Cluster headache No Yes
Migraine headache No Yes

Eyes:

Cataracts No Yes
Glaucoma No Yes

Ears:

Hearing loss from aging No Yes
Hearing loss from trauma No Yes

Nose and Sinus:

Nasal Allergies No Yes

Heart and Blood Vessels:

High / Elevated Cholesterol No Yes
High Blood pressure No Yes

Lungs and Respiratory:

Asthma No Yes
Chronic Bronchitis No Yes
Emphysema No Yes

Stomach and Digestive:

Gallbladder Inflammation No Yes
Gastrointestinal reflux No Yes
Ulcerative colitis No Yes
Stomach ulcer No Yes

Mental & Emotional:

Depression No Yes
Anxiety No Yes

Glands, Hormones, and Sugar Control:

Diabetes No Yes
Thyroid deficiency No Yes
Thyroid excess No Yes

Allergies, Immune & Infectious Problems:

HIV No Yes
Infectious mononucleosis No Yes

Are you pregnant? No Yes

Other (not listed) _____

SURGERIES AND HOSPITALIZATIONS

Have had problems with anesthesia (being numbed or put to sleep)? No Yes

Have had any ear nose or throat surgery? No Yes (type and date) _____

List any other surgeries you have had _____

Have you ever been hospitalized for non-surgical reasons? No Yes

If so please explain _____

FAMILY HISTORY

Specific Anesthesia Problem Mother Father Brother Sister

Ears:

Hearing Loss before age 20 Mother Father Brother Sister

Hearing Loss after age 20 Mother Father Brother Sister

Nose and Sinus:

Chronic Sinus Disease Mother Father Brother Sister

Heart and Blood Vessels:

Heart Disease Mother Father Brother Sister

High Blood Pressure Mother Father Brother Sister

Lungs and Respiratory:

Asthma Mother Father Brother Sister

Lung Cancer Mother Father Brother Sister

Brain and Nervous:

Stroke Mother Father Brother Sister

Blood & Lymph Node problems:

Bleeding/clotting problem Mother Father Brother Sister

Other _____ Mother Father Brother Sister

SOCIAL HISTORY

What is or was your occupation? _____ Check here if you are retired.

Have you ever used tobacco in any form? No Yes

If yes, please complete the following:

Type of Tobacco	From year	To year
Cigarettes per day: _____		
Other: (list type) _____		

Do you consume alcohol? No Yes

If yes, please complete the following:

Type of Alcohol	How Much	How often

Are you exposed to second hand smoke? No Yes

Do you use drugs recreationally? No Yes If yes, please list _____

What is your dominant hand? Right Left

How much caffeine do you consume? none 1 drink per day 2-3 drinks per day more than 4 drinks per day

REVIEW OF SYSTEMS: Mark yes or no and CHECK any of the following you have recently had

General health problems No Yes

(fever, sleeping problems, unintentional weight loss)

(freq non-productive cough, freq productive cough,

shortness of breath, wheezing)

Head or Face problems No Yes

(headache, face pain)

Stomach problems No Yes

(abdominal pain, diarrhea, heartburn, nausea, vomiting)

Eye problems No Yes

(blurred vision, loss of vision painful eye)

Bones, Joints and Muscles No Yes

(pain in back, painful joints, stiffness, swelling of joints)

Ear problems No Yes

(hearing loss, dizziness, ringing, painful ear)

Brain or Nervous system problems No Yes

(change in alertness, loss of bladder control, loss of consciousness, severe face pain)

Mouth & Throat problems No Yes

(change in voice, snoring, sore throat, ulcers)

Problems with Glands, Hormones No Yes

(increased appetite, increased fatigue, neck has enlarged, unwanted weight change)

Neck problems No Yes

(neck masses or lumps, pain, swollen glands)

Problems with Blood or Lymph nodes No Yes

(bleeds excessively after injury, bruises easily)

Heart or circulation problems No Yes

(blacking out or fainting, chest pain, irregular heartbeat, swelling of ankles)

Problems with Allergies No Yes

(food intolerances, freq sneezing, hives, post nasal drainage, severe reaction to insect bites)

Lung or respiratory problems No Yes

C/History

Other (not listed) _____

What is the main reason you are seeing the doctor today? _____