

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.

Social Security Number (SSN) _____ Appointment Date _____

Full Name _____ Male Female Date of Birth _____

Pharmacy Preference (include location) _____

Name of Primary Care (Family) Physician _____ Address _____

Name of Referring Physician _____ Address _____

CURRENT MEDICATIONS

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

MEDICATION ALLERGIES: ARE YOU ALLERGIC TO ANY MEDICATIONS? NO YES IF YES, PLEASE LIST BELOW.

Name of Medication	Type of Reaction

NON-MEDICATION ALLERGIES:

Are you allergic to anything in the environment such as pollens, dust, food, etc.? NO YES

If yes, please indicate what you are allergic to: _____

Have you ever had an allergy test? NO YES

If yes, which did you have? Skin Test... when? _____ Blood Test... when? _____

PAST HEALTH HISTORY:

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

Cancer (type) NO YES What Year? _____

Hepatitis NO YES What Year? _____

EARS:

Reflux NO YES What Year? _____

Ear Infections NO YES What Year? _____

Stomach ulcer NO YES What Year? _____

Hearing Loss NO YES What Year? _____

KIDNEY AND GENDER PROBLEMS:

Meniere's disease NO YES What Year? _____

Are you pregnant? NO YES What Year? _____

NOSE AND SINUS:

Chronic Sinusitis NO YES What Year? _____

Kidney Stones NO YES What Year? _____

Nasal Allergies NO YES What Year? _____

Renal failure NO YES What Year? _____

Nasal Polyps NO YES What Year? _____

BONES, JOINTS AND MUSCLES:

Arthritis (Rheumatoid) NO YES What Year? _____

MOUTH AND THROAT:

Sleep Apnea NO YES What Year? _____

MENTAL & EMOTIONAL:

Depression NO YES What Year? _____

HEART AND BLOOD VESSELS:

Arrhythmia NO YES What Year? _____

Anxiety NO YES What Year? _____

(Irregular Heartbeat Requiring Treatment)

GLANDS, HORMONES, AND SUGAR CONTROL:

High / Elevated Cholesterol NO YES What Year? _____

Diabetes NO YES What Year? _____

High Blood Pressure NO YES What Year? _____

Thyroid deficiency NO YES What Year? _____

(Irregular Heartbeat Requiring Treatment)

Thyroid Excess NO YES What Year? _____

LUNGS AND RESPIRATORY:

Asthma NO YES What Year? _____

BLOOD & LYMPH NODE PROBLEMS:

Anemia NO YES What Year? _____

Tuberculosis NO YES What Year? _____

Bleeding Disorder NO YES What Year? _____

STOMACH AND DIGESTIVE:

Duodenal Ulcer NO YES What Year? _____

ALLERGIES, IMMUNE & INFECTIOUS PROBLEMS:

HIV NO YES What Year? _____

Lupus NO YES What Year? _____

SURGERIES AND HOSPITALIZATIONS:

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

If yes, please list what sort of problems. _____

Have you ever had ear, nose or throat surgery? No Yes

If yes, list any surgeries and when they were done. _____

Have you been hospitalized for a medical problem before? No Yes

If yes, list hospitalizations, the reason for admission and the date. _____

FAMILY HISTORY

Specific Anesthesia Problem Mother Father Brother Sister

Ears:

Hearing Loss Before age 20 Problem Mother Father Brother Sister

Hearing Loss after age 20 Problem Mother Father Brother Sister

Nose and Sinus:

Nasal Allergies Problem Mother Father Brother Sister

Nasal Polyps Problem Mother Father Brother Sister

Heart and Blood Vessels:

Heart Disease Problem Mother Father Brother Sister

High Blood Pressure Problem Mother Father Brother Sister

Lungs and Respiratory:

Asthma Problem Mother Father Brother Sister

Lung Cancer Problem Mother Father Brother Sister

Brain and Nervous:

Stroke Mother Father Brother Sister

Blood & Lymph Node problems:

Bleeding/clotting problem Mother Father Brother Sister

Other Problem 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)		

Are you exposed to second hand smoke? No Yes

Do you use drugs recreationally? No Yes

If yes, please list _____

Do you consume alcohol? No Yes

If yes, please complete the following:

Type of Alcohol	How Much	How Often

Do you have pets? _____

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

Head or Face problems No Yes

headache, face pain

Eye problems No Yes

double vision, itchy eyes

Ear Problems No Yes

ear pain, ear drainage, hearing loss, dizziness, ringing

Nose & Sinus problems No Yes

chronic congestion, hay fever, sinus drainage

Mouth & Throat problems No Yes

change in voice, snoring, sore throat, ulcers

Neck problems No Yes

neck masses or lumps, pain, swollen glands

Heart or circulation problems No Yes

blacking out or fainting, bluish discoloration of lips or fingernails,

chest pain, irregular heartbeat, leg cramps, swelling of ankles

Lung or respiratory problems No Yes

freq non-productive cough, freq productive cough, shortness of breath,

wheezing

Stomach problems No Yes

abdominal pain, diarrhea, heartburn, nausea, vomiting

Brain or Nervous system problems No Yes

numbness, seizures, severe face pain, weakness

Problems with Glands, Hormones No Yes

feel cold all the time, feel hot when others do not, increased appetite,

increased fatigue, neck has enlarged, unwanted weight change

Problems with Blood or Lymph nodes No Yes

bleeds excessively after injury, bruises easily

Problems with Allergies No Yes

food intolerances, freq sneezing, hives, post nasal drainage,

severe reaction to insect bites

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

