

Patient History Information

Name: _____ Date: _____ Date of Birth: _____

Family Doctor: _____ Referring Doctor: _____

What is the reason for your visit today? _____

How long has the present problem been? _____

How often does it occur? _____ AM/PM, all the time? _____

What treatments have you had? _____

Please list any allergies to medications: _____

Please list all medications, including aspirin, over the counter medications, birth control: _____

Past Medical History: Have you ever been treated for the following medical conditions? Check yes or no and then circle all that apply. You may add additional information if necessary.

Yes No Allergies (seasonal, medications, rash) _____

Yes No Arthritis (rheumatoid, osteo-degenerative) _____

Yes No Blood Diseases (anemia, leukemia, clotting problems) _____

Yes No Diabetes (type, how controlled, when diagnosed?) _____

Yes No Thyroid Disease (hypo, hyper, Graves Disease) _____

Yes No Lung Disease (asthma, COPD, emphysema, chronic bronchitis, pneumonia) _____

Yes No Heart Disease (heart attack, angina, arrhythmia, heart failure, valve, bypass, pacemaker) _____

Yes No High Blood Pressure _____

Yes No Gastrointestinal Disease (reflux, ulcers, intestinal, liver disease) _____

Yes No Genito-urinary Disease (kidney disease, dialysis, kidney stones) _____

Yes No Neurological problems (strokes, seizures, paralysis, headache, dizziness) _____

Yes No Skin Diseases (eczema, psoriasis, acne) _____

Yes No Mental Health (depression, anxiety, schizophrenic, bipolar, panic) _____

Yes No Cancer (list type or location & date) _____

Yes No Infectious Disease (TB, syphilis, gonorrhea, AIDS, HIV, hepatitis) _____

Yes No Fibromyalgia (TMJ, facial pain) _____

Yes No Other problems: _____

Yes No **Previous Surgery** (date/type) _____

Previous ENT Surgery (tonsils, ear tubes, throat, neck or sinus surgery, etc.) _____

Social History:

What is your marital status? married single widowed

Do you live alone? Yes No

Do you smoke? Yes No If yes, ___ packs per day x ___ years. Quit ___ y ago

Do you drink alcohol? Yes No If yes, how much? _____ Quit ___ y ago

Are you employed? Yes No Occupation? _____

Are you pregnant? Yes No Breast Feeding? Yes No

SEE OTHER SIDE

Family History: Do you have a family history of disease? Please list the relative.

- Yes No Cancer _____
- Yes No Diabetes _____
- Yes No Hearing Loss _____
- Yes No Heart Disease _____
- Yes No Allergies _____
- Yes No Bleeding Disorder _____

Review of Systems: Do you currently have any of the following problems? Check yes or no then circle all that apply:

- Yes No Migraine, headache
- Yes No Weakness, imbalance, dizziness, vertigo, Meniere's
- Yes No Hearing loss, ringing in the ears
- Yes No Ear infections, cholesteatoma, ear drainage, ear odor
- Yes No Ear drum perforation, ear trauma, ear pain
- Yes No Eye problems, double vision
- Yes No Sinus pain, facial pressure
- Yes No Nose bleeding, nose dripping, nasal itching, post nasal dripping
- Yes No Face Trauma, Broken Nose, Accident
- Yes No Snoring, sleep apnea, gasping for breath at night
- Yes No Jaw joint pain
- Yes No Sore throat, tonsil problems, mouth bleeding
- Yes No Difficulty swallowing, fullness, lump in throat
- Yes No Hoarseness, raspy voice, coughing up blood
- Yes No Cough, phlegm
- Yes No Abnormal thyroid level
- Yes No Neck pain, lumps in the neck, swelling in the neck, masses in the neck
- Yes No Chest pain, palpitations
- Yes No High Blood Pressure
- Yes No Shortness of Breath, wheezing
- Yes No Heartburn, abdominal pain, diarrhea
- Yes No High/low blood sugar
- Yes No Joint Pain
- Yes No Easy bruising (hematological)
- Yes No Pain with urination, blood in urine
- Yes No Leg cramps, varicose veins, clots in the veins
- Yes No Chronic fatigue, weight loss
- Yes No Depression/anxiety
- Yes No Rashes, dryness of skin
- Yes No Cosmetic Concerns: facial skin care, Botox, Restylane, Contour Thread, other procedures

Signature

Relationship to Patient

Reviewed by Clinician

Date