EAR, NOSE, THROAT & SINUS CENTER - PATIENT HEALTH HISTORY

Full Name _____ **DOB** _____ **Height** _____ **Weight** _____

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

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 grass, dust, or food? ☐ **No** ☐ **Yes**
If yes, please indicate what you are allergic to. _____
Are you allergic to Latex? ☐ **No** ☐ **Yes** **Are you allergic to IV Contrast Dye?** ☐ **No** ☐ **Yes**

CURRENT MEDICATIONS: Are you taking ANY medications now? ☐ **No** ☐ **Yes** **If yes, please list below *including dosage*.**
(This includes prescription, over-the-counter and herbal medications)

Medication Name	Dosage	How often taken

Do you take Aspirin daily ☐ **No** ☐ **Yes** **Dose:**_____

TESTS AND IMMUNIZATIONS:
Are your immunizations up to date? ***(CHILDREN ONLY)*** ☐ **No** ☐ **Yes**

PAST HEALTH HISTORY: Have you ever been *DIAGNOSED* with any of the following problems?

ALLERGIC RHINITIS / HAY FEVER ☐ **No** ☐ **Yes**
ANEMIA/BLOOD DISORDER ☐ **No** ☐ **Yes**
ANEURYSM ☐ **No** ☐ **Yes**
ANXIETY DISORDER ☐ **No** ☐ **Yes**
ASTHMA ☐ **No** ☐ **Yes**
ATHEROSCLEROSIS ☐ **No** ☐ **Yes**
AUTOIMMUNE DISORDER ☐ **No** ☐ **Yes**
BLEEDING DISORDER ☐ **No** ☐ **Yes**
BOWEL PROBLEMS ☐ **No** ☐ **Yes**
CANCER ☐ **No** ☐ **Yes**
SPECIFY:_____
CARDIAC ARRHYTHMIA / ATRIAL FIBRILLATION ☐ **No** ☐ **Yes**
CAROTID BLOCKAGE ☐ **No** ☐ **Yes**
CORONARY ARTERY DISEASE ☐ **No** ☐ **Yes**
DIABETES, TYPE I or II (circle) ☐ **No** ☐ **Yes**
EAR PROBLEMS ☐ **No** ☐ **Yes**
HEART DISEASE/ HEART ATTACK/ CONGESTIVE HEART FAILURE ☐ **No** ☐ **Yes**
HEARTBURN / REFLUX ☐ **No** ☐ **Yes**
HEPATITIS / LIVER DISEASE ☐ **No** ☐ **Yes**
HIV/AIDS ☐ **No** ☐ **Yes**
HYPERTENSION ☐ **No** ☐ **Yes**
KIDNEY DISEASE ☐ **No** ☐ **Yes**
MIGRAINES ☐ **No** ☐ **Yes**
NASAL POLYPS ☐ **No** ☐ **Yes**
NERVE DISEASE ☐ **No** ☐ **Yes**
NOSEBLEEDS ☐ **No** ☐ **Yes**
PULMONARY DISEASE / COPD / EMPHESEMA ☐ **No** ☐ **Yes**
RECURRENT EAR INFECTIONS ☐ **No** ☐ **Yes**
RECURRENT SINUSITIS ☐ **No** ☐ **Yes**
RECURRENT TONSILLITIS ☐ **No** ☐ **Yes**
SEIZURES ☐ **No** ☐ **Yes**
SKIN PROBLEMS ☐ **No** ☐ **Yes**
SLEEP APNEA ☐ **No** ☐ **Yes**
STROKE ☐ **No** ☐ **Yes**
THYROID DISEASE ☐ **No** ☐ **Yes**

FAMILY HISTORY: **Do any of your family members have any of the medical illnesses listed above?** ☐ **No** ☐ **Yes**

RELATIONSHIP:	**MEDICAL ILLNESSES:**
Mother:	
Father:	
Sister:	
Brother:	
Child:	

SOCIAL HISTORY:

Have you ever used Tobacco in any form? ☐ **No** ☐ **Yes**

Type of Tobacco	How Many Years	Year Quit
Packs of Cigarettes a day: ___		
Other: (list type) _____		

Do you consume Alcohol? ☐ **No** ☐ **Yes**

Type of Alcohol	How Much	How Often

Do you use Recreational Drugs? ☐ **No** ☐ **Yes**

Are you exposed to Second Hand Smoke? ☐ **No** ☐ **Yes**

DO YOU CURRENTLY HAVE:

FEVER:	☐ NO	☐ YES
DOUBLE VISION:	☐ NO	☐ YES
DIFFICULTY HEARING:	☐ NO	☐ YES
RUNNY NOSE:	☐ NO	☐ YES
HOARSENESS:	☐ NO	☐ YES
HEADACHES:	☐ NO	☐ YES
CHEST PAIN:	☐ NO	☐ YES
SHORTNESS OF BREATH:	☐ NO	☐ YES
VOMITING:	☐ NO	☐ YES
BLEEDING PROBLEMS:	☐ NO	☐ YES
MUSCLE ACHES:	☐ NO	☐ YES
RASH:	☐ NO	☐ YES

SURGERIES AND HOSPITALIZATIONS:

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

If yes, please list the problems that occurred. _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING SURGERIES?

EARS:			**YEAR:**
EAR TUBES	☐ **NO**	☐ **YES**	_____
OTHER EAR SURGERY: _____			_____
NOSE AND SINUS:			
NASAL POLYP REMOVAL	☐ **NO**	☐ **YES**	_____
SINUS SURGERY	☐ **NO**	☐ **YES**	_____
SEPTOPLASTY	☐ **NO**	☐ **YES**	_____
OTHER NASAL SURGERY: _____			_____
MOUTH AND THROAT:			
ADENOIDECTOMY	☐ **NO**	☐ **YES**	_____
TONSILLECTOMY	☐ **NO**	☐ **YES**	_____
OTHER MOUTH OR THROAT SURGERY: _____			_____
NECK:			
PAROTID GLAND REMOVAL	☐ **NO**	☐ **YES**	_____
SUBMANDIBULAR GLAND REMOVAL	☐ **NO**	☐ **YES**	_____
THYROIDECTOMY (PARTIAL / TOTAL)	☐ **NO**	☐ **YES**	_____
OTHER NECK SURGERY: _____			
HEART AND BLOOD VESSEL:			
HEART SURGERY	☐ **NO**	☐ **YES**	_____
VASCULAR SURGERY	☐ **NO**	☐ **YES**	_____
CANCER SURGERY:	☐ **NO**	☐ **YES**	_____
TYPE: _____			

THORACIC:			**YEAR:**
RESECTION OF LUNG TUMOR	☐ **NO**	☐ **YES**	_____
OTHER LUNG SURGERY: _____			_____
ABDOMINAL/ GENITOURINARY:			
HERNIA REPAIR	☐ **NO**	☐ **YES**	_____
GALLBLADDER REMOVAL	☐ **NO**	☐ **YES**	_____
LIVER SURGERY	☐ **NO**	☐ **YES**	_____
PANCREAS SURGERY	☐ **NO**	☐ **YES**	_____
SPLEEN REMOVAL	☐ **NO**	☐ **YES**	_____
APPENDECTOMY	☐ **NO**	☐ **YES**	_____
COLON RESECTION	☐ **NO**	☐ **YES**	_____
BARIATRIC SURGERY	☐ **NO**	☐ **YES**	_____
PROSTATE SURGERY	☐ **NO**	☐ **YES**	_____
HYSTERECTOMY	☐ **NO**	☐ **YES**	_____
TUBAL LIGATION	☐ **NO**	☐ **YES**	_____
OTHER ABDOMINAL/GENITOURINARY SURGERY: _____			
BONE:			
BACK SURGERY	☐ **NO**	☐ **YES**	_____
OTHER BONE SURGERY: _____			
BRAIN SURGERY	☐ **NO**	☐ **YES**	_____
OTHER SURGERY: _____			