

PATIENT HEALTH HISTORY (ENT)

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.

Patient's Last Name _____ First _____ MI _____ Appointment Date _____
 Date of Birth: _____ SSN#: _____ Ht.: _____ Wt.: _____ BP: _____ Gender: M F
 Name of YOUR Pharmacy _____ Pharmacy Address _____
 Pharmacy Phone # _____ Full Name of Your Primary Care (Family) Physician _____
 Name of Referring Provider _____ Reason for Referral _____
 HNSA Doctor You Will Be Seeing _____

(TAB 1) PLEASE LIST ALL MEDICATIONS CURRENTLY BEING USED (PLEASE PRINT NEATLY)

Are you taking ANY kind of medication now? (This includes prescription, over-the-counter and herbal medications)
 No Yes If yes, please list below.

Name of Medication	Dosage	How Often Taken
		___ Daily ___ Twice a Day ___ 3 Times Daily ___ Other
		___ Daily ___ Twice a Day ___ 3 Times Daily ___ Other
		___ Daily ___ Twice a Day ___ 3 Times Daily ___ Other
		___ Daily ___ Twice a Day ___ 3 Times Daily ___ Other
		___ Daily ___ Twice a Day ___ 3 Times Daily ___ Other
		___ Daily ___ Twice a Day ___ 3 Times Daily ___ Other
		___ Daily ___ Twice a Day ___ 3 Times Daily ___ Other
		___ Daily ___ Twice a Day ___ 3 Times Daily ___ Other

(TAB 2) Are you ALLERGIC to ANY MEDICATION? No Yes If yes, please list below.

Name of Medication	Type of Reaction
	___ Nausea ___ Rash ___ Short of Breath ___ Shock
	___ Nausea ___ Rash ___ Short of Breath ___ Shock

(TAB 3) NON - MEDICATION ALLERGIES

Are you ALLERGIC to:	Dust	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Type of Reaction	___ Nausea	___ Rash	___ Shock
	Mold	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Type of Reaction	___ Nausea	___ Rash	___ Shock
	Pollen	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Type of Reaction	___ Nausea	___ Rash	___ Shock
	Latex gloves	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Type of Reaction	___ Nausea	___ Rash	___ Shock
	Tape	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Type of Reaction	___ Nausea	___ Rash	___ Shock
	Iodine	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Type of Reaction	___ Nausea	___ Rash	___ Shock
	Contrast dye	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Type of Reaction	___ Nausea	___ Rash	___ Shock

Have you had any allergy testing? No Yes (if Yes) Skin Test Blood Test Date: _____

Results: _____

Have You Ever Taken Allergy Shots? No Yes (if Yes) Date Started: _____ Date Completed: _____

(TAB 4) PAST HEALTH Ever been *DIAGNOSED* with any major health problem? Mark the appropriate items.

CANCER: Yes Type _____ Year: _____

HEAD and FACE

Migraine headache _____ Yes

EYES

Dry Eyes _____ Yes

Glaucoma _____ Yes

EARS

Chronic or frequent ear Infections _____ Yes

Hearing loss from aging _____ Yes

Hearing loss, unknown cause _____ Yes

NOSE and SINUSES

Nasal Allergies _____ Yes

Nasal Polyps _____ Yes

Recurrent Sinusitis _____ Yes

MOUTH and THROAT

Recurrent Tonsillitis _____ Yes

Sleep Apnea _____ Yes

TMJ Disorder _____ Yes

HEART & BLOOD VESSELS

Heart Attack _____ Yes

Heart Disease _____ Yes

High Blood Pressure _____ Yes

LUNGS & RESPIRATORY

Asthma _____ Yes

Emphysema _____ Yes

Pneumonia _____ Yes

Tuberculosis _____ Yes

Are you pregnant? _____ Yes

STOMACH & DIGESTIVE

Cirrhosis or enlarged liver _____ Yes

Hepatitis (Type A, B, or C) _____ Yes

Reflux _____ Yes

Stomach ulcer _____ Yes

KIDNEY & URINARY TRACT:

Prostate Enlargement _____ Yes

Renal Failure _____ Yes

BONES, JOINTS, and MUSCLES

Arthritis, unspecified _____ Yes

SKIN:

Eczema _____ Yes

BRAIN & NERVOUS SYSTEM:

Epilepsy _____ Yes

Multiple sclerosis _____ Yes

Stroke _____ Yes

MENTAL and EMOTIONAL HEALTH

Anxiety _____ Yes

Depression _____ Yes

GLANDS, HORMONES, & SUGAR CONTROL

Diabetes, unknown type _____ Yes

Thyroid Deficiency _____ Yes

Thyroid Excess _____ Yes

BLOOD & LYMPH NODES

Hemophilia _____ Yes

Von Willebrand's Disease _____ Yes

IMMUNE & INFECTIOUS

HIV _____ Yes

Lupus _____ Yes

(TAB 5) SURGERIES AND HOSPITALIZATIONS

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

If yes, please list what sort of problems. _____

Have you ever had any of the following SURGERIES? No If YES, mark any of the following you have had:

EARS

Ear Tubes _____ Yes Year _____

Replace / repair of ear drum (Tympanoplasty)

or mastoidectomy _____ Yes Year _____

NOSE and SINUSES

Nasal fracture repair _____ Yes Year _____

Nasal polypectomy _____ Yes Year _____

Nasal Septoplasty _____ Yes Year _____

Sinus Surgery _____ Yes Year _____

MOUTH and THROAT

Adenoidectomy _____ Yes Year _____

Tonsillectomy _____ Yes Year _____

NECK

Remove Parathyroid Glands _____ Yes Year _____

Remove Thyroid Gland _____ Yes Year _____

Non-Thyroid Cancer Surgery _____ Yes Year _____

HEART AND BLOOD VESSELS

Angioplasty _____ Yes Year _____

Bypass _____ Yes Year _____

Carotid Endarterectomy _____ Yes Year _____

Pacemaker Insertion _____ Yes Year _____

LUNG AND CHEST

Esophagus Removal _____ Yes Year _____

Lung Removal _____ Yes Year _____

OTHER SURGERIES NOT LISTED _____ Year _____

Have you been hospitalized for a **MEDICAL ILLNESS** before? No Yes
 If yes, list hospitalizations, the reason for admission, and the approximate date(s) of admission. _____

(TAB 6) SERIOUS INJURIES

Have you ever had a serious injury such as head, neck, back, or other injury? No Yes
 If yes, list and describe the type of injury and when it occurred _____

(TAB 7) IMMUNIZATIONS Up to date Incomplete

(TAB 8) FAMILY HISTORY Not known

Anesthesia Problems: Mother Father Brother Sister

Head and Face:
 Headache Mother Father Brother Sister

Ears:
 Hearing Loss before age of 20 Mother Father Brother Sister
 Hearing Loss after age of 20 Mother Father Brother Sister

Heart and Blood Vessels:
 Heart Disease Mother Father Brother Sister
 High Blood Pressure Mother Father Brother Sister

Lungs and Respiratory:
 Lung Cancer Mother Father Brother Sister
 Asthma Mother Father Brother Sister

Brain and Nervous:
 Stroke Mother Father Brother Sister

Glands, Hormone, Sugar Control:
 Diabetes (age of onset unknown). Mother Father Brother Sister

Blood & Lymph Node problems:
 Bleeding/clotting prob. Mother Father Brother Sister

Cancer – TYPE _____
 Mother Father Brother Sister

(TAB 9) SOCIAL HISTORY

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

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)		

Have you ever used alcohol in any form? No Yes If yes, please complete the following:

Type of Alcohol	From year:	To year:
Beers per week:		
Wine glasses per week:		
Other: (list type)		

Are you exposed to second-hand smoke? Yes No

Have / do you use other drugs? Yes No If yes, please list type: _____

Caffeine use: None 1 cup/day 2-3 cups/day 4 or more cups/day

(TAB 10) REVIEW OF SYSTEMS: MARK any problems you have or have recently had in the following areas.

General Health

No Yes (fatigue, fever, unintentional weight loss, unintentional weight gain)

Eyes

No Yes (dry, loss of vision sensitivity to light)

Ears

No Yes (ear pain; ear infection; hearing loss, ringing in ears)

Nose and Sinuses

No Yes (congestion; frequent colds, frequent nose bleeds, hay fever; sinus drainage)

Mouth and Throat

No Yes (change in voice, snoring, sore throats trouble swallowing)

Heart and Blood Vessels

No Yes (chest pain, irregular heart beat)

Lungs and respiratory system

No Yes (frequent productive cough, shortness of breath, wheezing)

Stomach and digestive system

No Yes (abdominal pain, heartburn, frequent nausea, painful swallowing, frequent vomiting)

Skin

No Yes (frequent fever blisters/cold sores, rash)

Brain and nervous system

No Yes (change in smell or taste, difficulty with balance, numbness, seizures, weakness)

Mental and Emotional health

No Yes (nervous (anxiety), sad thoughts more than usual (depressed))

Blood and lymph nodes

No Yes (bleeds excessively after injury, bruise easily)

Allergies, infections, immune system

No Yes (frequent sneezing, hives, unusual infections)

History of Syndrome (Genetic Disease)

No Yes If yes, please name: _____

Please list any other physicians involved in your care:

Physician Name _____	Physician Name _____
Phone Number _____	Phone Number _____
FAX Number _____	FAX Number _____

Physician Name _____	Physician Name _____
Phone Number _____	Phone Number _____
FAX Number _____	FAX Number _____

Patient's Signature: _____ **Date:** _____