ENT Ear, Nose & Throat Specialty Care

# Adult Medical History Form

**Today's Date:** _____ / _____ /_____

**PATIENT NAME:** Please Print

_____

(First Name) (M) (Last Name)

**DATE OF BIRTH:** _____ / _____ /_____ **Name of primary physician:** _____

**Name of doctor that sent you here (if different than above):** _____

**I. Reason for visit:** _____

**II. Medication History**

**Prescription drugs you take now:** ☐ None

_____

_____

_____

_____

_____

**Over the counter medications you take now:** ☐ None

☐ Aspirin ☐ Ibuprofen

☐ Other pain medicine, Name: _____

☐ Nasal spray, Name:_____

☐ Allergy pill, Name: _____

☐ Antacid pill, Name: _____

☐ Others: _____

**III. Medical History:** ☐ None

☐ Anesthesia problems ☐ Asthma/ lung disease ☐ Easy bleeding or bruising problems

☐ Glaucoma ☐ Heart disease ☐ Hypertension

☐ Cataracts ☐ Thyroid disease ☐ Tuberculosis ☐ Stroke

☐ Autoimmune disorders ☐ Diabetes ☐ Seizure ☐ Sleep apnea

☐ Cancer (if yes, list type): _____

☐ Other health conditions: _____

**IV: Allergies:**

**i. Do you have any allergies to drugs or medications:** ☐ **Yes** ☐ **No**

If yes, list medication and reaction: _____

**ii. Do you have any environmental, food or latex allergies:** ☐ **Yes** ☐ **No**

If yes, list allergy and reaction: _____

**V. Surgical History:** Have you ever had surgery? ☐ **Yes** ☐ **No**

If yes, list:

_____ Date: _____

_____ Date: _____

_____ Date: _____

**VI. Family History:** Has anyone in your family have or had any of the listed problems? ☐ **None** ☐ **Family History Unknown**

☐ Anesthesia problems Who: _____

☐ Easy bleeding or bruising problems Who: _____

☐ History of frequent ear infections Who: _____

☐ Hearing loss Who: _____

☐ Environmental allergies Who: _____

**VII: Social History:**

**1. Tobacco Use and Smoking:** ☐ Non-smoker ☐ Former smoker
☐ Smoker (less than 10 cigarettes per day) ☐ Smoker (more than 10 cigarettes per day)

**2. Alcohol Use:** ☐ No ☐ Less than 6 drinks per week ☐ More than 6 drinks per week

**3. Recreational Drug Use:** ☐ No ☐ Yes

**4. Occupation:** _____

**VIII. Review of Symptoms:** Check box for problems you have **now.** If no problems in that area now, check "no problems".

**Ear Nose Throat (ENT)**
☐ NO PROBLEMS
☐ Ear pain
☐ Hearing loss
☐ Dizziness
☐ Nasal congestion
☐ Snoring
☐ Sore throat
☐ Hoarseness
☐ Lump in neck

**Constitutional**
☐ NO PROBLEMS
☐ Fever
☐ Fatigue
☐ History of MRSA infection

**Endocrine**
☐ NO PROBLEMS
☐ Cold or heat intolerance

**Heart**
☐ NO PROBLEMS
☐ Chest pains
☐ Palpitations

**Neurologic**
☐ NO PROBLEMS
☐ Headaches
☐ Numbness
☐ Weakness

**Eyes**
☐ NO PROBLEMS
☐ Blindness
☐ Double vision
☐ Eye pain

**Blood**
☐ NO PROBLEMS
☐ Anemia
☐ Bleeding or bruising easily

**Lungs**
☐ NO PROBLEMS
☐ Shortness of breath
☐ Chronic cough
☐ Wheezing
☐ Sleep apnea

**Digestive**
☐ NO PROBLEMS
☐ Heartburn/ acid reflux
☐ Swallowing problems

**Skin**
☐ NO PROBLEMS
☐ Hives
☐ Itching