Ear, Nose & Throat *SpecialtyCare* of Minnesota, P.A. **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 the 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 or cataracts ☐ Heart Disease ☐ Hypertension ☐ Stroke

☐ Sleep apnea ☐ Thyroid Disease ☐ Tuberculosis ☐ Autoimmune disorders

☐ Cancer (if yes, list type) __________________ ☐ Diabetes ☐ Seizure

☐ 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: Does anyone in 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:__________________

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VII: Social History:

1. Tobacco Use and Smoking: ☐ Non-smoker ☐ Former smoker
☐ Smoker (less than 10 cigaretes 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 / sleep apnea
☐ Sore Throat
☐ Hoarseness
☐ Lump in neck

Constitutional

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

Heart

☐ NO PROBLEMS
☐ Chest Pains
☐ Palpitations

Lungs

☐ NO PROBLEMS
☐ Shortness of breath
☐ Chronic cough
☐ Wheezing
☐ Sleep Apnea

Digestive

☐ NO PROBLEMS
☐ Heartburn / Acid Reflux
☐ Swallowing problems

Neurologic

☐ NO PROBLEMS
☐ Headaches
☐ Weakness
☐ Numbness

Endocrine

☐ NO PROBLEMS
☐ Cold or heat intolerance

Skin

☐ NO PROBLEMS
☐ Hives
☐ Itching

Eyes

☐ NO PROBLEMS
☐ Blindness
☐ Double Vision
☐ Eye pain

Blood

☐ NO PROBLEMS
☐ Anemia
☐ Bleeding or bruising easily