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: Does anyone in your family have/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 (Every day) ☐ Smoker (Some days, not every day)
If "Current smoker': How many cigarettes do you smoke?
☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31 or more
If "Current Smoker': How soon after waking do you smoke your first cigarette?
☐ 6-30 min ☐ 31-60 ☐ after 60- min
If "Current Smoker'" Are you interested in quitting?
☐ Ready to quit ☐ Thinking about quitting ☐ Not ready to quit

2. Did you have a drink containing alcohol in the past year?
☐ Yes ☐ No
If 'Yes' : How often did you have a drink containing alcohol in the past year?
☐ Monthly or less ☐ 2 to 4 drinks a month ☐ 2-3 times a week ☐ 4 or more times a week
If 'Yes': How many drinks did you have on a typical day?
☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more
If 'Yes': How often did you have 6 or more drinks on one occasion in the past year?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

3. Recreational Drug Use: ☐ No ☐ Yes

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