ENT Ear, Nose & Throat Specialty Care

Adult Medical History Form

Today's Date:____/____/____

PATIENT NAME: ____ **DATE OF BIRTH**:____/____/____

(First Name) (MI) (Last Name)

Gender: ☐ **Male** ☐ **Female** ☐ **Other:**____________ **Primary #:** ________________ **Email:**____________________

Home Address: ________________________________ **City:**_______________ **State:**______ **Zip Code:**________

Name of primary physician:______________________ **Name of referring physician:** ________________________

Pharmacy Name and City: ________________________________ **Phone #:**______________

Insurance Name/Policy #:______________________ **Policy Holder Name/Date of Birth:**______________________

Emergency Contact: __________________________ **Relationship:** ______________ **Phone #:**______________

I. Reason for visit: ____

II. Medication History

Prescription drugs you take now: ☐ None

________________________ ________________________ ________________________

________________________ ________________________ ________________________

Over the counter medications you take now: ☐ None ☐ Aspirin ☐ Ibuprofen ☐ Tylenol

☐ Nasal Spray, Name: ________________________ ☐ Allergy medication, Name: ________________________

☐ Antacid medication: ________________________ ☐ Other: ________________________

III. Medical History: ☐ None

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

☐ Anxiety ☐ Heart disease ☐ Hypertension

☐ Depression ☐ Thyroid disease ☐ Seizure

☐ Autoimmune disorders ☐ Diabetes

☐ Stroke ☐ Sleep apnea

☐ Cancer (if yes, list type): ____

☐ Other medical concerns: ____

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: ________________

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)
   ☐ Smokeless tobacco (every day) ☐ Smokeless tobacco (some days, not every day)

2. **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

3. **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 - 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 - 2 ☐ 3 - 4 ☐ 5 - 6 ☐ 7 - 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

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

5. **Occupation:** ________________________

VIII. Review of Symptoms: Check box for problems you have now.

Ear Nose Throat (ENT)

☐ Ear pain
☐ Hearing loss
☐ Dizziness
☐ Nasal congestion
☐ Snoring
☐ Sore throat
☐ Hoarseness
☐ Lump in throat

Lungs

☐ Shortness of breath
☐ Chronic cough
☐ Wheezing
☐ Sleep apnea

Constitutional

☐ Fever
☐ Fatigue
☐ History of MRSA infection

Endocrine

☐ Cold or heat intolerance

Digestive

☐ Heartburn/acid reflux
☐ Swallowing problems

Heart

☐ Chest pains
☐ Palpitations

Neurologic

☐ Headaches
☐ Numbness
☐ Weakness

Skin

☐ Hives
☐ Itching

Eyes

☐ Blindness
☐ Double vision
☐ Eye pain

Blood

☐ Anemia
☐ Bleeding or bruising easily

Print Name:________________________ Signature:________________________ Date:______________