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:**_____________ **Phone #(required):** ____________________ **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 six or more drinks on one occasion in the past year?
☐ Never ☐ Monthly or less ☐ 2-4 drinks a month ☐ 2-3 times a week ☐ 4 or more times a week ☐ Declined
If 'Yes': How many drinks did you have on a typical day?
☐ 1- 2 drinks ☐ 3-4 drinks ☐ 5-6 drinks ☐ 7- 9 drinks ☐ 10 or more drinks ☐ Declined
If 'Yes': How often did you have a drink containing alcohol in the past year?
☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ Daily/almost daily ☐ Declined

4. Recreational Drug Use: ☐ No ☐ Yes

5. Occupation: ____

CONSENT TO COMMUNITCATE

I authorize Ear, Nose & Throat Specialty Care to communicate with the following person(s) regarding my medical care and information:

Name	Relationship	Phone Number	Scheduling	Medical	Billing
			Y N	Y N	Y N
			Y N	Y N	Y N
			Y N	Y N	Y N

The above Consent to Communicate authorization will expire 36 months from the date signed unless an earlier date is provided here:____________________.

Print Name:____________________________________ Signature:________________________________Date:_________________