Medical History

Name _____ Date _____ Height:_____ Weight:_____

What is the main reason for your visit today? _____

Medication Allergies (please list) _____

List Present Medication and Dosage (or provide list) _____

_____

Please list over the counter medications, vitamins or supplements you take _____

Do you take Aspirin/Motrin/Coumadin/Plavix on a regular basis? ☐ Yes ☐ No Have you ever had any bleeding problems? ☐ Yes ☐ No

Ear, Nose & Throat History

Please check all that apply.

☐ Hearing Aids R L Both
☐ Hearing Loss
☐ Ear Pain
☐ Frequent Ear Infections
☐ Ringing in Ear R L Both
☐ Nose Bleeds
☐ Chronic Sinus Infections
☐ Sinus Headaches
☐ Snoring
☐ Decreased Sense of Smell/Taste
☐ Change in Voice
☐ Heartburn
☐ Frequent Sore Throats
☐ Hoarseness
☐ Balance Disturbance (Vertigo/Spinning)

Have you had previous Ear, Nose or Throat Surgery or Injuries? ☐ Yes ☐ No
If yes please list operations, injuries and dates: _____

_____

Please list any other procedures or operations you've had and dates _____

_____

Medical History

Have you ever had, or do you have (check all that apply) ……

☐ AIDS ☐ Chemical Dependency ☐ Eye Disease ☐ High Cholesterol ☐ Panic Attacks
☐ Anemia ☐ Diabetes ☐ Heart Disease ☐ Hypertension ☐ Stroke
☐ Arthritis ☐ Depression ☐ Hepatitis ☐ Kidney Disease ☐ Stent (heart)
☐ Anxiety ☐ Emphysema ☐ Herpes ☐ Liver Disease ☐ Thyroid Disorder
☐ Cancer ☐ Epilepsy/Seizures ☐ HIV ☐ Pacemaker ☐ Venereal Disease

Family History

Please check all that apply.

	Yes	No	Family member(s) relation to patient
Asthma	☐	☐	_____
Cancer	☐	☐	_____
Bleeding Disorder	☐	☐	_____
Heart Disease	☐	☐	_____
Hearing Loss	☐	☐	_____

Has any member of your family been seen in this practice? ☐ Yes ☐ No

Names _____

Have you ever had any difficulty with anesthesia? ☐ Yes ☐ No
If yes, please describe reaction:
_____

Social History

Please check all that apply.

Smoke Tobacco: ☐ Yes ☐ No If yes, pack per day? _____ for _____ years. If quit, when_____

Alcohol: ☐ Yes ☐ No Drinks per day? _____ Caffeine: ☐ Yes ☐ No Cups per day? _____

Smokeless Tobacco: ☐ Yes ☐ No Cocaine: ☐ Yes ☐ No Marijuana: ☐ Yes ☐ No

I certify this information is true and correct to best of my knowledge. I will notify you of any changes in the above information.

Patient Signature _____ Physician Signature _____