

ENT & ALLERGY

ASSOCIATES P.S.

Medical History

Patient Name _____ What is the reason for your visit today? _____

Patients name printed

Findings/Diagnosis _____

Date of last doctors visit: _____ Physician: _____

EARS, NOSE & THROAT SYMPTOMS NOW PRESENT: (PLEASE CHECK ALL THAT APPLY)

- | | | |
|--|---|--|
| <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Draining from Ears | <input type="checkbox"/> Ringing Ears |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hearing Loss/Decreased Hearing | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Recurring Sore Throat | <input type="checkbox"/> Strep Throat | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Swallowing Difficulty | <input type="checkbox"/> Sore in Mouth | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Nasal Blockage | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Enlarged Glands | <input type="checkbox"/> Strange Odor or Taste | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Coughing Up Blood | <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Growth in Neck/Throat |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |

PERSONAL HISTORY OF PATIENT: (PLEASE CHECK ALL THAT APPLY)

- | | | |
|---|--|---|
| <input type="checkbox"/> Bleeding Problem | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Nervous Disorder |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Nephritis (Kidney Problems) | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Polio | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> TB |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Problem with General Anesthesia | <input type="checkbox"/> Other: _____ |
- Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____
- Do you smoke? ☐ Yes ☐ No If yes, how much? _____

FAMILY HISTORY & BLOOD RELATIVES: (PLEASE CHECK ALL THAT APPLY)

- | | | |
|--|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> TB | <input type="checkbox"/> Problem with General Anesthesia | <input type="checkbox"/> Epilepsy/Seizure Disorder |
| <input type="checkbox"/> Suicide | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other health problems in the family: _____ |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heart Condition | |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Hearing Loss | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer | |

ALLERGIES (PLEASE CHECK ALL THAT APPLY)

- | | | |
|-------------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Morphine | <input type="checkbox"/> Bees |
| <input type="checkbox"/> Sulfa | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Pollen |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Medicated | <input type="checkbox"/> Other: _____ |

LIST ALL OPERATIONS/HOSPITALIZATIONS (USE BACK OF PAGE IF NECESSARY)

Type/Date/Age _____ Physician _____

Type/Date/Age _____ Physician _____

Type/Date/Age _____ Physician _____

Were you ever advised to have an operation that was not performed? ☐ Yes ☐ No

Please list any medication you are now taking (sleeping pills, nose sprays, ear or eye drops, tranquilizers, aspirin, cortisone, vitamins etc.)

X _____

Signature of patient or parent/guardian is minor

Date