

Advanced Ear, Nose and Throat Medical History Form

Patient Name _____ Today's date _____

Please answer this questionnaire to the best of your knowledge. The information is confidential and will be used by the staff of Advanced Ear, Nose and Throat for evaluation and treatment.

1. MEDICATIONS

List all your current over the counter and prescription medications: _____

2. ALLERGIES

Are you allergic to any medications? foods? _____

3. SOCIAL *(Please circle your response)*

Do you drink alcoholic beverages? Yes No Occasional Moderate Heavy

Do you use tobacco? Yes No Never smoked Previous smoker Chew
Smoke < 1 pack/day Smoke 1-2 pack/day Smoke 2-3 pack/day

Do you use any recreational drugs? Yes No

4. SURGERIES: Please list any ear, nose and throat surgeries and any other major surgeries/hospitalizations in your lifetime. _____

5. ILLNESSES OR CONDITION: Are you under the care of a doctor for a specific illness/condition or have you been treated in the past for: *(Please check your response)*

	Yes	No		Yes	No
Allergies	()	()	Kidney/Bladder	()	()
Anemia	()	()	Lungs	()	()
Asthma	()	()	Meningitis	()	()
Autoimmune disease	()	()	Migraine Headaches	()	()
Bleeding disorders	()	()	Mitral Valve Prolapse	()	()
Bone or joint	()	()	Nasal Trauma	()	()
Cancer	()	()	Nervous System	()	()
Chemical Dependency	()	()	Nosebleeds	()	()
COPD	()	()	Reflux/GERD/heartburn	()	()
Diabetes	()	()	Seizure Disorder	()	()
Hearing Loss	()	()	Sinusitis	()	()
Heart	()	()	Sleep Apnea	()	()
Hepatitis	()	()	Stomach or Bowels	()	()
HIV	()	()	Thyroid	()	()
High Cholesterol	()	()	Tinnitus/Ringing in the ears	()	()
Hypertension	()	()	Tuberculosis	()	()
Hypotension	()	()			

6. FAMILY HISTORY:

Allergies	()	()	Premature Hearing Loss	()	()
Asthma	()	()	Sinusitis	()	()
Autoimmune Disease	()	()	Sleep Apnea	()	()
ENT related cancers	()	()	Thyroid Disorders	()	()
Migraine Headaches	()	()			