Advanced Ear, Nose & Throat Medical History Form

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.

Patient Name: ______________________________ Today's Date: ____________________

ILLNESSES OR CONDITIONS: Please indicate if you have ever been under the care of a physician for any of the following illnesses/conditions by placing an "X" in the appropriate box. Each time you select "yes," please give all applicable details.

	Yes	No	Details		Yes	No	Details
Allergies (Food)	[ ]	[ ]		Kidney/Bladder	[ ]	[ ]	
Allergies (Nasal)	[ ]	[ ]		Latex Sensitivity	[ ]	[ ]	
Anemia	[ ]	[ ]		Lung Disease	[ ]	[ ]	
Asthma	[ ]	[ ]		Meningitis	[ ]	[ ]	
Autoimmune Disease	[ ]	[ ]		Migraines	[ ]	[ ]	
Bleeding Disorders/Easy Bruising	[ ]	[ ]		Nasal Trauma	[ ]	[ ]	
Bone/Joint	[ ]	[ ]		Nosebleeds	[ ]	[ ]	
Cancer	[ ]	[ ]		Reflux or Heartburn	[ ]	[ ]	
Chest Pain/Tightness	[ ]	[ ]		Sinusitis	[ ]	[ ]	
Diabetes	[ ]	[ ]		Skin Cancer	[ ]	[ ]	
Eczema	[ ]	[ ]		Skin Disease	[ ]	[ ]	
Headaches	[ ]	[ ]		Sleep Apnea/Loud Snoring	[ ]	[ ]	
Hearing Loss	[ ]	[ ]		Snoring	[ ]	[ ]	
Heart Disease	[ ]	[ ]		Stomach/Bowels	[ ]	[ ]	
Heart Murmur	[ ]	[ ]		Stroke	[ ]	[ ]	
Hepatitis	[ ]	[ ]		Thyroid Disorder	[ ]	[ ]	
High Blood Pressure	[ ]	[ ]		Tinnitus/Ringing in Ears	[ ]	[ ]	
High Cholesterol	[ ]	[ ]		Tuberculosis	[ ]	[ ]	
HIV	[ ]	[ ]		Ulcers	[ ]	[ ]	
Hives	[ ]	[ ]		Chemical Dependency	[ ]	[ ]	

SURGERIES: Please list any previous surgeries/hospitalizations and their dates. Include details of complications, if applicable.

	Operation	Date	Notes/Details of Complications
1.			
2.			
3.			
4.			

FAMILY HISTORY: Please indicate whether or not any of your family members have ever been under the care of a physician for the following illnesses/conditions by placing an "X" in the appropriate box. Each time you select "yes," please list your relation to the afflicted family member (mother, brother, paternal grandfather, etc).

	Yes	No	Afflicted Family Member(s)		Yes	No	Afflicted Family Member(s)
Abnormal Bleeding	[ ]	[ ]		Hearing Loss	[ ]	[ ]	
Abnormal Clotting	[ ]	[ ]		Heart Disease	[ ]	[ ]	
Allergies	[ ]	[ ]		High Blood Pressure	[ ]	[ ]	
Anesthesia Problems	[ ]	[ ]		Migraines	[ ]	[ ]	
Breast Cancer	[ ]	[ ]		Sinusitis	[ ]	[ ]	
Asthma	[ ]	[ ]		Skin Cancer	[ ]	[ ]	
Autoimmune Disorders	[ ]	[ ]		Skin Disease	[ ]	[ ]	
Cancer	[ ]	[ ]		Sleep Apnea	[ ]	[ ]	
Diabetes	[ ]	[ ]		Thyroid Disorders	[ ]	[ ]	
Headaches	[ ]	[ ]					

ALLERGIES: Please list all allergies to medications, foods and/or latex. Include any necessary notes.

	Allergy	Reaction	Notes
1.			
2.			
3.			
4.			
5.			
6.			

MEDICATIONS: Please list all your current over the counter and prescription medications.

	Drug	Dosage	Prescribed by	Bad Reaction?
1.				
2.				
3.				
4.				
5.				
6.				

SOCIAL HISTORY: Please indicate your answers to the following questions/assert which of the following statements are true by placing an "X" in the appropriate box(es).

	No	Yes, Socially	Yes, Daily
Do you drink alcoholic beverages?	[ ]	[ ]	[ ]
Do you use recreational drugs?	[ ]	[ ]	[ ]

I have never smoked cigarettes		[ ]
I chew tobacco		[ ]
I smoke an occasional cigarette or cigar		[ ]
I smoke every day	How many packs?	[ ]
I am an ex-smoker		[ ]

If you are an ex-smoker, please complete the following statements by placing an "X" in the appropriate box(es). If you are a current smoker, or have never been a smoker, please skip to the section labeled "Patient Ability to Heal"

When I was smoking, I smoked:

Less than 1 pack per day	[ ]
More than 1 pack per day	[ ]

I quit smoking:

In the last year	[ ]
In the last 5 years	[ ]
In the last 10 years	[ ]
More than 10 years ago	[ ]

PATIENT ABILITY TO HEAL:

	Yes	No
Does your skin appear fragile, or burn easily?	[ ]	[ ]
Do you form thick or raised scarring from a cut or burn?	[ ]	[ ]
Do you ever get cold sores?	[ ]	[ ]

FEMALE QUESTIONS:

	Yes	No	N/A
Do you have regular periods?	[ ]	[ ]	[ ]
Are you going through menopause?	[ ]	[ ]	[ ]
Are you pregnant or lactating?	[ ]	[ ]	[ ]
During pregnancy, did you ever get hyperpigmentation or masking?	[ ]	[ ]	[ ]

HEIGHT AND WEIGHT: Height: _____feet _____inches Weight: ______ pounds

VERIFICATION: By signing (or typing, if filled out electronically) my name and today's date below, I assert that all of the information provided above is accurate and complete to the best of my knowledge.

Patient Name: ________________________________ Today's Date: ____________________