

Medical History

Name _____ Date _____
Last First Middle

Primary Physician _____ Referred by _____

Chief Complaint (Reason for today's visit) _____

SECTION II – HISTORY OF PRESENT ILLNESS (Please be thorough)

- (1) Location of problem (ear, nose, throat) _____
- (2) Quality (i.e. sharp, stabbing pain, achy, burning, fullness, etc.) _____
- (3) Severity (i.e. mild, moderate, severe) _____
- (4) Duration (i.e. length of time symptoms present) _____
- (5) Timing (i.e. after meals, bedtime, morning, etc.) _____
- (6) Associated signs/symptoms (fever, nausea, etc.) _____
- (7) Modifying factors (rest, movement, eating) _____
- (8) Context (anything that causes symptoms) _____

SECTION III – PAST HISTORY

Medical Conditions (list all including those below that apply) _____

Check conditions that apply:

Asthma ___ Heart Disease ___ High Blood Pressure ___ Diabetes ___
Hepatitis ___ Bleeding Disorders ___ Kidney Failure ___ Cancer & Type _____

Current Medications & dosages _____

Preferred Pharmacy Name & Location : _____

I am allergic to the following medications: _____

List all prior ENT (Ear, Nose, Throat) surgeries: _____

Other surgeries: _____

Have you noticed a decrease in your hearing or have you noticed people mumbling? Y N

Do you hear words but you do not always understand? Y N

Do you find it difficult to hear in noisy places? Y N

Have you noticed ringing, roaring, or sizzling noises in your ears? Y N

SOCIAL HISTORY:

Tobacco Y N Amount per day _____

Alcohol Y N Amount/Frequency _____

Exercise Y N Type ?Frequency _____

Occupation : _____

FAMILY HISTORY:

List prevalent health problems or causes of death of close family members:

Anesthetic Complications: _____ Bleeding Tendencies: _____

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Review of Systems

Please check either normal or past/current problems from each system listed:

Constitutional	Eyes	ENT	Cardiovascular	Respiratory	Gastrointestinal	Genitourinary
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal
<input type="checkbox"/> achiness	<input type="checkbox"/> seeing double	<input type="checkbox"/> ear pain	<input type="checkbox"/> palpitations	<input type="checkbox"/> COPD	<input type="checkbox"/> nausea/vomiting	<input type="checkbox"/> kidney stones
<input type="checkbox"/> fatigue	<input type="checkbox"/> dry eyes	<input type="checkbox"/> hoarseness	<input type="checkbox"/> passing out	<input type="checkbox"/> short of breath	<input type="checkbox"/> heartburn/reflux	<input type="checkbox"/> bladder infection
<input type="checkbox"/> night sweats	<input type="checkbox"/> drainage	<input type="checkbox"/> nasal drainage	<input type="checkbox"/> high cholesterol	<input type="checkbox"/> Asthma	<input type="checkbox"/> irritable bowel	<input type="checkbox"/> kidney failure
<input type="checkbox"/> fever	<input type="checkbox"/> itching	<input type="checkbox"/> sore throat	<input type="checkbox"/> heart attack	<input type="checkbox"/> Emphysema	<input type="checkbox"/> constipation	<input type="checkbox"/> blood in urine
	<input type="checkbox"/> sensitive to sun	<input type="checkbox"/> nasal congestion	<input type="checkbox"/> heart failure	<input type="checkbox"/> wheezing	<input type="checkbox"/> diarrhea	<input type="checkbox"/> urinary frequency
	<input type="checkbox"/> cataracts	<input type="checkbox"/> ear infections	<input type="checkbox"/> stroke	<input type="checkbox"/> cough		<input type="checkbox"/> trouble urinating
	<input type="checkbox"/> blurry vision	<input type="checkbox"/> dizzy spells	<input type="checkbox"/> chest pains	<input type="checkbox"/> pneumonia	<input type="checkbox"/> difficult to swallow	<input type="checkbox"/> impotency
	<input type="checkbox"/> glaucoma	<input type="checkbox"/> nose bleeds	<input type="checkbox"/> murmur	<input type="checkbox"/> sleep problems	<input type="checkbox"/> bowel obstruction	<input type="checkbox"/> enlarged prostate
	<input type="checkbox"/> blindness	<input type="checkbox"/> sinus problems	<input type="checkbox"/> high blood pressure		<input type="checkbox"/> abdominal pain	
	<input type="checkbox"/> glasses	<input type="checkbox"/> tonsillitis	<input type="checkbox"/> phlebitis	<input type="checkbox"/> phlebitis	<input type="checkbox"/> Hepatitis	
	<input type="checkbox"/> contacts	<input type="checkbox"/> allergies	<input type="checkbox"/> leg/foot swelling	<input type="checkbox"/> leg/foot swelling		
		<input type="checkbox"/> difficulty swallowing	<input type="checkbox"/> CAD	<input type="checkbox"/> CAD		
			<input type="checkbox"/> mitral prolapse	<input type="checkbox"/> mitral prolapse		
Musculoskeletal	Integumentary	Neurological	Psychological	Endocrine	Hematological	Allergies
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal
<input type="checkbox"/> joint pain	<input type="checkbox"/> abnormal mole	<input type="checkbox"/> numbness	<input type="checkbox"/> fibromyalgia	<input type="checkbox"/> fatigue	<input type="checkbox"/> nausea/vomiting	<input type="checkbox"/> urticarid
<input type="checkbox"/> hernias	<input type="checkbox"/> hives	<input type="checkbox"/> seizures	<input type="checkbox"/> Insomnia	<input type="checkbox"/> weight gain/loss	<input type="checkbox"/> swollen lymph node	<input type="checkbox"/> sneezing
<input type="checkbox"/> arthritis	<input type="checkbox"/> rashes	<input type="checkbox"/> headaches	<input type="checkbox"/> depression	<input type="checkbox"/> goiter	<input type="checkbox"/> easy bruising	<input type="checkbox"/> rashes
<input type="checkbox"/> broken bones	<input type="checkbox"/> infections	<input type="checkbox"/> dizzy spells	<input type="checkbox"/> chronic fatigue	<input type="checkbox"/> excessive thirst	<input type="checkbox"/> AIDS/HIV	
<input type="checkbox"/> joint replacement	<input type="checkbox"/> skin cancer	<input type="checkbox"/> paralysis	<input type="checkbox"/> anxiety	<input type="checkbox"/> heat/cold intolerance	<input type="checkbox"/> sickle cell anemia	
		<input type="checkbox"/> Insomnia	<input type="checkbox"/> eating disorders	<input type="checkbox"/> diabetes	<input type="checkbox"/> anemia	
		<input type="checkbox"/> head injury	<input type="checkbox"/> ADHD	<input type="checkbox"/> thyroid disease	<input type="checkbox"/> Hepatitis	
				<input type="checkbox"/> steroid use		
				<input type="checkbox"/> night sweats		
				<input type="checkbox"/> Adrenal disorder		
				<input type="checkbox"/> menopause		