PROVIDENCE EAR NOSE AND THROAT ASSOCIATES

PATIENT MEDICAL HISTORY FORM

PATIENT NAME: _____ AGE: _____ DOB _____ TODAY'S DATE: _____

THE FOLLOWING INFORMATION IS VERY IMPORTANT TO YOUR HEALTH.
PLEASE TAKE THE TIME TO FULLY AND ACCURATELY COMPLETE THIS FORM. THANK YOU

WHAT IS THE REASON FOR YOUR VISIT?

PAST MEDICAL HISTORY *INDICATE IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS.*

- ☐ ANESTHESIA PROBLEMS
- ☐ ANXIETY
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ BLOOD TRANSFUSION
- ☐ CANCER
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ EMPHYSEMA
- ☐ EXPOSURE TO TB
- ☐ GLAUCOMA/EYE PROBLEMS
- ☐ HAZARD. CHEM. EXPOSURE
- ☐ HEALING PROBLEMS (KELOIDS
- ☐ HEART ATTACK
- ☐ HEARTBURN OR REFLUX
- ☐ HEPATITIS
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ HIV OR AIDS
- ☐ KIDNEY PROBLEMS
- ☐ NEUROLOGIC DISORDERS
- ☐ NOISE EXPOSURE
- ☐ PREMATURITY OR BIRTH PROBLEMS
- ☐ PREVIOUS HEAD OR NECK IRRADIATION
- ☐ PREVIOUS TRAUMA
- ☐ PSYCHIATRIC CONDITION
- ☐ SEIZURE/ EPILEPSY
- ☐ STOMACH PROBLEMS
- ☐ STROKE OR TIA
- ☐ THYROID PROBLEMS

PAST SURGICAL HISTORY

- ☐ TONSILLECTOMY/ADENOIDECTOMY
- ☐ EAR TUBES OR SURGERY
- ☐ SINUS OR NASAL SURGERY
- ☐ OTHER HEAD AND NECK SURGERY

EXPLAIN ANY OF THE CONDITIONS YOU HAVE CHECKED ABOVE IN THE SPACE BELOW. PLEASE LIST ANY OTHER SURGERIES, CONDITIONS, INJURIES, OR HOSPITALIZATIONS YOU MAY HAVE THAT ARE NOT LISTED ABOVE,

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ YES ☐ NO
IF YES, LIST THE MEDICATIONS TO WHICH YOU ARE ALLERGIC AND YOUR REACTION.

MEDICATIONS *LIST THE MEDICATIONS AND DOSAGES YOU TAKE. PLEASE INCLUDE BLOOD THINNERS, VITAMINS, OTC MEDICATIONS, BIRTH CONTROL, HERBAL PREPARATIONS AND NASAL SPRAYS*

PHYSICIANS *PLEASE LIST YOUR PRIMARY PHYSICIAN AND ALL OTHER PHYSICIANS TREATING YOU*

FEMALE PATIENTS ANY CHANCE YOU ARE PREGNANT? ☐ YES ☐ NO NURSING? ☐ YES ☐ NO
IF PATIENT IS A CHILD ARE IMMUNIZATIONS UP TO DATE? ☐ YES ☐ NO

FAMILY MEDICAL HISTORY *INDICATE IF ANY FAMILY MEMBERS HAVE ANY OF THE FOLLOWING CONDITIONS*

- ☐ ALLERGY
- ☐ CANCER
- ☐ HEARING LOSS
- ☐ THYROID DISEASE
- ☐ BLEEDING PROBLEMS
- ☐ ANESTHESIA PROBLEMS

LIST ANY OTHER MAJOR FAMILY ILLNESSES BELOW.

REVIEW OF SYMPTOMS *INDICATE IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS NOW OR IN THE PAST*

NOW	PAST		NOW	PAST	
☐	☐	PROBLEMS SLEEPING	☐	☐	BUZZING OR RINGING IN THE EARS
☐	☐	DAYTIME SLEEPINESS OR FATIGUE	☐	☐	HEARING LOSS
☐	☐	DIFFICULTY RELAXING/CONCENTRATING	☐	☐	EARACHE OR EAR ITCH
☐	☐	LOSS OF APPETITE	☐	☐	EAR PRESSURE OR FULLNESS
☐	☐	FEVERS, CHILLS	☐	☐	FREQUENT EAR INFECTIONS
☐	☐	NIGHT SWEATS	☐	☐	WEAR HEARING AIDS
☐	☐	WEIGHT GAIN OR LOSS	☐	☐	STUFFY BLOCKED NOSE
☐	☐	SHORTNESS OF BREATH	☐	☐	SEASONAL OR YEAR ROUND ALLERGIES
☐	☐	CHEST PAIN	☐	☐	SNEEZING
☐	☐	IRREG HEARTBEAT OR PALPITATIONS	☐	☐	SNORING
☐	☐	CHANGE IN VISION	☐	☐	IRRITABLE, WATERY, ITCHY EYES
☐	☐	REGURGITATION OF MEALS	☐	☐	FREQUENT SINUS INFECTIONS
☐	☐	PAINFUL SWALLOWING	☐	☐	LOSS OF TASTE OR SMELL
☐	☐	DIFFICULTY SWALLOWING	☐	☐	FREQUENT COLDS
☐	☐	EXCESS STOMACH GAS/BELCHING	☐	☐	POST NASAL DRIP/RUNNY NOSE
☐	☐	HEARTBURN	☐	☐	RECURRENT NOSE BLEEDS
☐	☐	BOWEL MOVEMENT PROBLEMS	☐	☐	HEADACHES
☐	☐	MUSCLE WEAKNESS	☐	☐	WHEEZING
☐	☐	SKIN GROWTHS OR RASHES	☐	☐	COUGH
☐	☐	HEAT OR COLD INTOLERANCE	☐	☐	FACIAL PAIN
☐	☐	EXCESSIVE BLEEDING/EASY BRUISING	☐	☐	TMJ, TOOTH OR JAW PAIN
☐	☐	PROBLEMS URINATING	☐	☐	NECK, FACE OR OTHER SWELLING
☐	☐	BONE PAIN OR FRACTURES	☐	☐	MOUTH ULCERS OR COLD SORES
☐	☐	JOINT SWELLING, PAIN OR STIFFNESS	☐	☐	HOARSENESS OR VOICE PROBLEM
☐	☐	COORDINATION/BALANCE CHANGE	☐	☐	NECK PAIN
☐	☐	DIZZINESS OR LIGHTHEADEDNESS	☐	☐	BAD BREATH
☐	☐	DRAINAGE FROM THE EARS	☐	☐	FREQUENT THROAT CLEARING
☐	☐	FREQUENT NAUSEA OR VOMITING	☐	☐	SORE OR SCRATCHY THROAT

TOBACCO USE ☐ NEVER ☐ QUIT/YEAR _____
☐ CIGARS ☐ CHEW ☐ CIGARETTES
HOW MANY PACKS PER DAY _____ FOR HOW MANY YEARS _____

ALCOHOL USE ☐ NEVER ☐ QUIT ☐ RARELY ☐ WEEKLY ☐ DAILY
WHAT TYPE AND HOW MUCH _____

DRUG USE ☐ NEVER ☐ QUIT ☐ RARELY ☐ WEEKLY ☐ DAILY
WHAT TYPE AND HOW MUCH_____

DIET WHICH OF THE FOLLOWING DO YOU EAT ON A REGULAR BASIS?
☐ TEA ☐ COFFEE ☐ CHOCOLATE ☐ MINTS ☐ CAFFINATED SODA
DO YOU SNACK BEFORE BED AT NIGHT? ☐ YES ☐ NO

MARRITAL STATUS ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

OCCUPATION *PLEASE LIST CURRENT AND PAST JOBS*

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY BELIEF.

_____ _____
PATIENT'S SIGNATURE DATE

PLEASE DO NOT WRITE BELOW THIS LINE.

☐ ROS UNOBTAINABLE. REASON: _____ ☐ ALL OTHER SYSTEMS ARE NEGATIVE
☐ HISTORY OBTAINED FROM (OTHER SOURCE) _____ ☐ NO OTHER SOURCE AVAILABLE
REMARKS: _____
_____
REVIEWED BY: _____ _____
PHYSICIAN'S SIGNATURE DATE