*PROVIDENCE EAR NOSE AND THROAT ASSOCIATES* ***Ht_____*** ***Wt:_____***

# 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 ARE YOUR REASONS FOR TODAYS VISIT?**

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

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

**PAST SURGICAL HISTORY**

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

*EXPLAIN ANY OF THE CONDITIONS YOU HAVE CHECKED ABOVE IN THE SPACE BELOW. PLEASE LIST 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 THE REACTION YOU EXPERIENCED.*

**MEDICATIONS:** *LIST ALL MEDICATIONS AND DOSAGES. PLEASE INCLUDE BLOOD THINNERS, VITAMINS, OTC MEDICATIONS, BIRTH CONTROL, HERBAL PREPARATIONS AND NASAL SPRAYS*

*(If on Diabetic Medications please list if for Diabetes or weight loss)*

**PHYSICIANS** *PLEASE LIST YOUR PRIMARY PHYSICIAN AND ALL OTHER PHYSICIANS CURRENTLY 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 | ☐ HEARING LOSS | ☐ BLEEDING PROBLEMS |
| ☐ CANCER | ☐ THYROID DISEASE | ☐ ANESTHESIA PROBLEMS |

*LIST ANY OTHER MAJOR FAMILY ILLNESSES BELOW.*

**OVER TO SIDE TWO →→→→**

**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

**MARITAL STATUS** □ SINGLE □ MARRIED □ SEPARATED □ DIVORCED □ WIDOWED

**OCCUPATION** *PLEASE LIST CURRENT AND PAST JOBS*

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**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