

NORTHEAST EAR, NOSE & THROAT ASSOC., INC.

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. Please fill out every item. It is important for your doctor to know you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Patient's Last Name _____ First _____ MI _____

Sex Male Female Date of Birth: _____ Height: _____ Weight: _____

Name of Primary Care Physician: _____

Pharmacy Preference (include location): _____

REASON FOR TODAY'S VISIT: _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Table with 3 columns: Name of Medication, Dosage, How Often Taken. Multiple empty rows for data entry.

ARE YOU ALLERGIC TO ANY MEDICATION? ___ Yes ___ No If yes, please list below:

Table with 2 columns: Name of Medication, Type of Reaction. Multiple empty rows for data entry.

Are you allergic to adhesive tape, seafood, latex, metal, iodine, contrast dye? (Circle positives) ___None

PAST HEALTH HISTORY: (circle positives)

Breast Cancer Lung Cancer Stomach Ulcer Prostate Cancer Other Cancer _____ Renal Failure Cataracts Glaucoma Nasal Allergies Sleep Apnea Deep Vein Thrombosis High/Elevated Cholesterol Heart Attack HIV Chronic Bronchitis Tuberculosis GERD Skin Cancer Throat Cancer Enlarged Prostate Migraine Headache Stroke Chronic Anxiety Diabetes Mellitus Thyroid Dysfunction Anemia Hemophilia Hypertension Asthma Emphysema

SURGERIES AND HOSPITALIZATIONS

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ___Yes ___No

If yes, please list type of problems: _____

*Please proceed to the next page.

NORTHEAST EAR, NOSE & THROAT ASSOC., INC.

List any surgeries you have had (including dates):

Have you ever been hospitalized for non-surgical reasons? ___ Yes ___ No

If yes, list reasons for hospitalizations _____

Immunizations: Last Flu shot – Date: _____ Last Pneumovax shot – Date: _____

Family History: (Circle Positives/specify relation)

Problems w/ Anesthesia _____ Cancer _____ Heart Disease _____ Hypertension _____

Asthma _____ Stroke _____ Diabetes _____ Lung Cancer _____

Bleeding/Clotting Problem _____ Thyroid Cancer _____

Hearing Loss prior to age 20 _____ Hearing Loss after age 20 _____

Social History: Y = yes N = no

Are you retired? Y or N **Current or most recent occupation:** _____

Tobacco Use: Mark your tobacco use: ___ None ___ Smokeless tobacco ___ Cigarettes ___ Cigars

Give the closest amount of cigarettes you smoke in an average day: ___ 1/2 pk ___ 1 pk ___ 1 1/2 pks ___ 2 pks ___ 3 pks

Alcoholic Beverages -- ___ Less than 12 drinks/year ___ 1-13 drinks per mo. ___ 4 -14 drinks per day ___ Greater than 2 drinks per day

Do you use drugs recreationally? Y or N

Caffeine use Y or N ___ None ___ 1 per day ___ 2 -3 per day ___ 4 or more ___

Are you exposed to second hand smoke? Y or N **Mark if patient attends daycare** ___ Yes

Home living situation? ___ Alone ___ w/ children ___ w/ mother ___ w/ father ___ w/ spouse ___ in assisted living
___ in nursing home ___ Other

Are you willing to accept blood transfusions? Y or N

Review of Systems: Y = yes N = no

ROS: General: fatigue Y or N fever Y or N wt. loss Y or N anorexia Y or N

Eyes: pain Y or N itching Y or N drainage Y or N swelling Y or N redness Y or N

Respiratory: SOB Y or N wheezing Y or N

Cardiac: chest pain Y or N palpitations Y or N swelling Y or N

GI: nausea Y or N vomiting Y or N diarrhea Y or N constipation Y or N food intolerance Y or N
dysphagia Y or N

Neuro: seizures Y or N numbness Y or N fainting Y or N tremors Y or N

Psychiatric: anxiety Y or N depression Y or N

Patient Signature: _____ **Date:** _____