

## 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)	<input type="checkbox"/>	<input type="checkbox"/>		Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies (Nasal)	<input type="checkbox"/>	<input type="checkbox"/>		Latex Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	
Anemia	<input type="checkbox"/>	<input type="checkbox"/>		Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	
Autoimmune Disease	<input type="checkbox"/>	<input type="checkbox"/>		Migraines	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding Disorders/Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>		Nasal Trauma	<input type="checkbox"/>	<input type="checkbox"/>	
Bone/Joint	<input type="checkbox"/>	<input type="checkbox"/>		Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Reflux or Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	
Chest Pain/Tightness	<input type="checkbox"/>	<input type="checkbox"/>		Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Eczema	<input type="checkbox"/>	<input type="checkbox"/>		Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Headaches	<input type="checkbox"/>	<input type="checkbox"/>		Sleep Apnea/Loud Snoring	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>		Snoring	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>		Stomach/Bowels	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>		Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>		Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		Tinnitus/Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>	
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>		Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	
HIV	<input type="checkbox"/>	<input type="checkbox"/>		Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	
Hives	<input type="checkbox"/>	<input type="checkbox"/>		Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	

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	<input type="checkbox"/>	<input type="checkbox"/>		Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal Clotting	<input type="checkbox"/>	<input type="checkbox"/>		Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies	<input type="checkbox"/>	<input type="checkbox"/>		High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Anesthesia Problems	<input type="checkbox"/>	<input type="checkbox"/>		Migraines	<input type="checkbox"/>	<input type="checkbox"/>	
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Autoimmune Disorders	<input type="checkbox"/>	<input type="checkbox"/>		Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		Thyroid Disorders	<input type="checkbox"/>	<input type="checkbox"/>	
Headaches	<input type="checkbox"/>	<input type="checkbox"/>					

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I have never smoked cigarettes	<input type="checkbox"/>
I chew tobacco	<input type="checkbox"/>
I smoke an occasional cigarette or cigar	<input type="checkbox"/>
I smoke every day	How many packs? <input type="checkbox"/>
I am an ex-smoker	<input type="checkbox"/>

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	<input type="checkbox"/>
More than 1 pack per day	<input type="checkbox"/>

I quit smoking:

In the last year	<input type="checkbox"/>
In the last 5 years	<input type="checkbox"/>
In the last 10 years	<input type="checkbox"/>
More than 10 years ago	<input type="checkbox"/>

PATIENT ABILITY TO HEAL:

	Yes	No
Does your skin appear fragile, or burn easily?	<input type="checkbox"/>	<input type="checkbox"/>
Do you form thick or raised scarring from a cut or burn?	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever get cold sores?	<input type="checkbox"/>	<input type="checkbox"/>

FEMALE QUESTIONS:

	Yes	No	N/A
Do you have regular periods?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you going through menopause?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant or lactating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During pregnancy, did you ever get hyperpigmentation or masking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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: \_\_\_\_\_