Ear Nose and Throat Center of Austin
ENT 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 that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcomed to a copy of the report if you wish.

Full Name _____ **Male** ☐ **Female**☐ **Date of Birth** _____

Pharmacy Preference (include location) _____

Name of Primary Care (Family) Physician _____ **Address** _____

(Current Medications)
Are you taking ANY kind of medication now? ☐ **No** ☐ **Yes** **If yes, please list below *include dosages*.**
(This includes prescription, over-the-counter medicines including nasal sprays, or herbal medications)

Medication Name	Dosage	How often taken

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ **No** ☐ **Yes** **If yes, please list**

Name of Medication	Type of Reaction

(Non-Medication Allergies) Are you allergic to Please Circle if allergic to: Eggs, Peanuts, Seafood, other _____
Iodine ☐ **No** ☐ **Yes** **Latex** ☐ **No** ☐ **Yes, Tape** ☐ **No** ☐ **Yes, Contrast Dye?** ☐ **No** ☐ **Yes**
Have you ever had an allergy test? ☐ **No** ☐ **Yes**
(Past Health History) Have you ever been *DIAGNOSED* with any of the following problems?

Cancer (bone cancer, lung cancer, unknown type of skin cancer, thyroid cancer) other _____☐ **No** ☐ **Yes**

Ears:
Hearing Loss ☐ **No** ☐ **Yes**
Cerumen Impaction ☐ **No** ☐ **Yes**

Nose and Sinus:
Nasal Allergies ☐ **No** ☐ **Yes**

Heart and Blood Vessels:
High / Elevated Cholesterol ☐ **No** ☐ **Yes**
High Blood pressure ☐ **No** ☐ **Yes**

Lungs and Respiratory:
Tuberculosis ☐ **No** ☐ **Yes**

Stomach and Digestive:
Duodenal ulcer ☐ **No** ☐ **Yes**
Hepatitis ☐ **No** ☐ **Yes**
Stomach ulcer ☐ **No** ☐ **Yes**

Genitourinary:
Renal failure ☐ **No** ☐ **Yes**

Are you pregnant? ☐ **No** ☐ **Yes**

Mental & Emotional:
Anxiety ☐ **No** ☐ **Yes**
Depression ☐ **No** ☐ **Yes**

Glands, Hormones, and Sugar Control:
Diabetes ☐ **No** ☐ **Yes**
Thyroid deficiency ☐ **No** ☐ **Yes**
Thyroid excess ☐ **No** ☐ **Yes**

Blood & Lymph Node problems:
Anemia ☐ **No** ☐ **Yes**

Allergies, Immune & Infectious Problems:
HIV ☐ **No** ☐ **Yes**
Infectious mononucleosis ☐ **No** ☐ **Yes**

(Surgeries and Hospitalizations)
Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ **No** ☐ **Yes**
If **yes**, please list what sort of problems. _____
Have you ever had ear, nose or throat surgery?☐ **No** ☐ **Yes**
If **yes**, list any surgeries and when they were done. _____
Have you been hospitalized for a medical problem before? ☐ **No** ☐ **Yes**
If **yes**, list hospitalizations, the reason for admission and the date. _____

(Family History)

Specific Anesthesia Problem ☐Mother ☐Father ☐Brother ☐Sister

Cancer:
Lung Cancer ☐Mother ☐Father ☐Brother ☐Sister

Ears:
Hearing Loss before age20 ☐Mother ☐Father ☐Brother ☐Sister
Hearing Loss after age 20 ☐Mother ☐Father ☐Brother ☐Sister

Nose and Sinus:
Nasal Allergies ☐Mother ☐Father ☐Brother ☐Sister

Heart and Blood Vessels:
Heart Disease ☐Mother ☐Father ☐Brother ☐Sister
Hypertension ☐Mother ☐Father ☐Brother ☐Sister

Lungs and Respiratory:
Asthma ☐Mother ☐Father ☐Brother ☐Sister

Brain and Nervous:
Stroke ☐Mother ☐Father ☐Brother ☐Sister

Blood & Lymph Node problems:
Bleeding/clotting problem ☐Mother ☐Father ☐Brother ☐Sister
Other_____ ☐Mother ☐Father ☐Brother ☐Sister

(Social History)

What is or was your occupation? _____ ☐ Check here if you are retired.

Have you ever used tobacco in any form? ☐ **No** ☐ **Yes**
If yes, please complete the following:

Type of Tobacco	From year	To year
Cigarettes per day: _____		
Other: (list type) _____		

Do you consume alcohol? ☐ **No** ☐ **Yes**
If yes, please complete the following:

Type of Alcohol	How Much	How often

Do you use drugs recreationally? ☐ **No** ☐ **Yes** **If yes, please list**_____
Are you exposed to second hand smoke? ☐ **No** ☐ **Yes**

(Review of Systems): Mark yes or no and CHECK any of the following you have recently had

Constitutional Symptoms ☐ **No** ☐ **Yes**
(☐Fever, ☐sleeping problems, ☐unintentional weight loss)

Eye problems ☐ **No** ☐ **Yes**
(☐Double vision, ☐itchy eyes)

Ears, Nose, Mouth and Throat problems ☐ **No** ☐ **Yes**
(☐Dizziness, ☐ear drainage, ☐hearing loss, ☐ear pain, ☐Ringing, ☐chronic congestion, ☐post-nasal drainage, ☐Hoarseness/change in voice, ☐snoring, ☐sore throat, ☐Ulcers)

Cardiovascular ☐ **No** ☐ **Yes**
(☐Blacking out or fainting, ☐Bluish discoloration of lips or fingernails, ☐chest pain, ☐irregular heartbeat, ☐leg cramps, ☐swelling of ankles)

Respiratory problems ☐ **No** ☐ **Yes**
(☐freq non-productive cough, ☐freq productive cough, ☐Shortness of breath, ☐wheezing)

Gastrointestinal problems ☐**No** ☐ **Yes**
(☐abdominal pain, ☐diarrhea, ☐heartburn, ☐nausea, ☐vomiting)

Musculoskeletal problems ☐ **No** ☐ **Yes**
(☐Neck pain)

Neurological problems ☐ **No** ☐ **Yes**
(☐Headache, ☐numbness, ☐severe face pain, ☐seizures, ☐weakness)

Problems with Endocrine ☐No ☐ Yes
(☐Appetite increased, ☐increased fatigue, ☐Feel hot when others do not, ☐feel cold all the time, ☐Neck has enlarged, ☐unwanted weight change)

Problems with Hematological/Lymphatic ☐ **No** ☐ **Yes**
(☐Bleeds excessively after injury, ☐bruises easily, ☐Neck masses or lumps)

Allergic, Infectious, Immunologic Problems ☐ **No** ☐ **Yes**
(☐Food intolerances, ☐hives**,** ☐Severe reaction to insect bites, ☐frequent sneezing)

What is the main reason you are seeing the doctor today?