PATIENT HISTORY FORM

Complete on first visit

Patient Name________________________________ Date______/________/_______

The following is a list of diseases. If you have ever had any of these, please check:

_____Abnormal Bleeding	_____ Epilepsy/Convulsions	_____Tonsillitis
_____Asthma	_____Goiter	_____Nose Bleeds
_____Cancer (Type? ______)	_____Headaches	_____Ear Infections
_____Heartburn/Gastric Reflux	_____Heart Ailments	_____Dizziness
_____Sinus Infection	_____Hay Fever, Seasonal Allergies	_____Difficulty Swallowing
_____Cough (frequent)	_____Jaw Pain(TMJ)	_____Skin Cancer
_____Diabetes	_____Lung Disorders	_____Sore Throat (frequent)
_____Decreased Hearing	_____Ringing in ears	_____Thyroid disease
_____Snoring	_____Sleep Apnea	_____Ear Pain

Did your PCP refer you or recommend that you see an Otolaryngologist (ENT Specialist)? YES NO

Who is your Primary Care Physician?____

Were you referred to us by another Specialist/Doctor other than PCP, if so whom?________________________________

What is your main reason for your visit today?____

List any previous surgeries you have had____

What medications are you allergic to? ____

List all medications that you are presently taking, including nasal sprays______________________________
____

Do you drink alcohol? ____________ If so, how often?________________________________
Do you or have you ever smoked? ________________ If so, how much & how long?______________________
Do you or have you ever used chewing tobacco? _________ If so, how much & how long?______________________
Do you drink caffeinated beverages? ____________ If so, how much?________________________________

Please list any blood relations who have had the below diseases.

Cancer, What type?____________________________ Early Hearing Loss_________________________
Thyroid Disease_______________________________ Heart Disease_____________________________
High Blood Pressure____________________________ Diabetes_________________________________
Allergies_____________________________________ Asthma______________________________