Otolaryngology Medical History

Patient Name: ____ Date of Birth: ________________________

Primary Care Provider: ________________________________ Referring Provider: ___________________

Reason for Today's Visit: ____

What treatment have you received for this condition? ____

____

Pharmacy/Address: ___________________________/____

Have you ever had: **Circle Answer**

- High Blood Pressure .... YES .... NO
- Heart Trouble .... YES .... NO
- Epilepsy or Seizures .... YES .... NO
- Excessive Bleeding or Bleeding Tendencies .... YES .... NO
- Diabetes .... YES .... NO
- Liver Disease, Hepatitis or Jaundice .... YES .... NO
- Kidney Disease .... YES .... NO
- Asthma or Chronic Lung Disease .... YES .... NO
- Stomach Ulcers .... YES .... NO
- Cancer/Type__________________________________ .... YES .... NO
- Serious Head Injury .... YES .... NO

- Are you allergic to any medication? .... YES .... NO
  If yes, please list them here ____
  ____
- Are you taking any medications (prescription, over the counter, herbal)? .... YES .... NO
  If yes, please list them here with dosage____
  ____
- Have you had your Flu Shot this year? .... YES .... NO
- Are you allergic to latex? .... YES .... NO
- Are you pregnant? .... YES .... NO
- Have you had a Mammogram this year? .... YES .... NO
- Do you smoke? .... YES .... NO
  If yes, how much?______________________________ If yes, how long?_________________________
- Have you ever smoked? .... YES .... NO
- Smoke free home? .... YES .... NO
- Do you drink alcohol? .... YES .... NO
  If yes, how much?______________________________ If yes, how often?_________________________

(PLEASE COMPLETE REVERSE SIDE)

- Have you ever had surgery?..YES ....NO

  If yes, please list surgeries and dates here:____

  ____

- Have you ever been hospitalized for a non-surgical condition?...............................YES ....NO

  If yes, please give reasons and dates here:____

  ____

Are you currently experiencing any of the following conditions?

Condition	Circle Answer	
Fevers	YES	NO
Chills	YES	NO
Blurry vision	YES	NO
Double vision	YES	NO
Hearing loss	YES	NO
Dizziness	YES	NO
Runny nose	YES	NO
Bloody nose	YES	NO
Snoring	YES	NO
Sore throat	YES	NO
Cough	YES	NO
Sneezing	YES	NO

Condition	Circle Answer	
Heartburn	YES	NO
Watery, Itchy eyes	YES	NO
Eye pain	YES	NO
Ringing in the ears	YES	NO
Ear pain	YES	NO
Stuffy nose	YES	NO
Sinus pain	YES	NO
Dry mouth	YES	NO
Hoarse voice	YES	NO
Shortness of breath	YES	NO
Gland swelling	YES	NO

Does anyone in your family have: (PLEASE LIST FAMILY MEMBER)

Hearing Loss ....YES____ NO

Heart Disease ....YES____ NO

High Blood Pressure ....YES____ NO

Cancers.................................YES____ NO

Diabetes................................YES____ NO

Problems with Anesthesia.....YES____ NO

Your Current Height:____________________________ Your Current Weight:________________________

Occupation:____

If retired, former Occupation:____

Any other information you would like us to know?_______________________________________

____

____

Patient Signature:____Date:________________________