WEST MICHIGAN EAR, NOSE & THROAT - PATIENT HEALTH HISTORY FORM

DATE_____

Patient Name:_____ Date of Birth_____

Height:_____ Weight:_____ Preferred Pharmacy:_____

CHIEF COMPLAINT

Reason for today's visit:_____

PAST MEDICAL HISTORY

Illnesses that **YOU** currently have or have been previously treated for (check all that apply):

____ Allergic Rhinitis
____ Anxiety
____ Asthma
____ Bleeding Disorder
____ Cancer (type)_____
____ Depression
____ Diabetes
____ Esophageal Reflux (GERD)
____ Heart Disease
____ High Blood Pressure
____ AIDS/HIV
____ High Cholesterol
____ Kidney Disease
____ Liver Disease/Hepatitis
____ Migraine Headaches
____ Seizure Disorder
____ Sleep Apnea
____ Stroke
____ Thyroid Disease
____ Tuberculosis (TB)
____ Other:_____

PAST SURGICAL HISTORY

Surgeries that **YOU** have previously undergone (check all that apply):

____ Adenoids
____ Appendix
____ Back/Neck Surgery
____ Heart Cath/Stent
____ Heart Bypass
____ Ear Tubes
____ Ear (other)_____
____ Gallbladder
____ Hernia Repair
____ Hip Surgery
____ Hysterectomy
____ Knee Surgery
____ Shoulder Surgery
____ Sinus Surgery
____ Thyroid
____ Tonsils

Anesthesia Problems? □Yes □No

CURRENT MEDICATIONS (include OTC, vitamins, etc)

Medication	Dose	Frequency

cont. on back if needed

ALLERGIES

Medication/Material/Food	Reaction

cont. on back if needed

FAMILY HISTORY

Do you have a **FAMILY** history of trouble with anesthesia? □ Yes □ No Easy Bleeding? □ Yes □ No

SOCIAL HISTORY

Do you smoke? □ Yes, I've smoked ____ packs of cigarettes for ____ years □ Yes, I smoke cigars or a pipe
□ No, I've never smoked □ No, I quit ____years ago. I smoked ____ packs of cigarettes for ____ years.

Do you drink alcohol?

□ No, never □ Occasional □ Light (<2/day) □ Moderate (2-3 /day) □ Heavy (>4/day) □ Prior Heavy Use

Do you use illicit drugs (including medical marijuana)? □ No □ Previous Use _____ □ Yes_____

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Patient Name:_____ Date of Birth_____

REVIEW OF SYSTEMS

Are **YOU** currently having, or ever had problems with (check all that apply):

Constitutional
____ Weight Gain
____ Weight Loss
____ Night Sweats
____ Insomnia
____ Fever

Allergic/Immunologic
____ Sneezing
____ Itching eyes/nose
____ Itchy Throat
____ Skin Rash
____ HIV
____ Food Allergy _____
____ Nasal Allergy

Eyes
____ Watery Eyes
____ Double Vision
____ Visual Loss
____ Eye Injuries

Ear, Nose, Throat & Mouth
____ Wears Hearing Aids
____ Hearing Loss
____ Ringing In the Ears
____ Ear Pain
____ Ear Infection
____ Ear Itching
____ Balance Problems
____ Nosebleeds
____ Inability to smell
____ Nasal Congestion
____ Nasal Drainage
____ Sinus Problems
____ Nasal Itching
____ Dry Mouth
____ Sore Throat
____ Sore Tongue
____ Trouble swallowing
____ Hoarseness

Respiratory
____ Chronic Cough
____ Coughing Blood
____ Asthma
____ Tuberculosis (TB)
____ Pneumonia
____ Trouble Breathing at Night
____ Snoring
____ Shortness of Breath
____ Bronchitis
____ Wheezing

Cardiovascular
____ Chest Pain or Angina
____ Heart Trouble
____ Rheumatic Fever
____ Heart Murmur
____ High Cholesterol
____ High Blood Pressure
____ Irregular pulse
____ Leg Swelling
____ Palpitations

Gastrointestinal
____ Indigestion or heartburn
____ Food Intolerance
____ Ulcer
____ Hepatitis
____ Jaundice
____ Blood in Stool
____ Black, Tarry Stool
____ Nausea
____ Vomiting
____ Abdominal Pain

Genitourinary
____ Bladder Trouble
____ Prostate Disease
____ Kidney Disease
____ Painful Urination
____ Blood in Urine
____ Kidney Stones

Musculoskeletal
____ Muscle Weakness
____ Joint Pain
____ Joint Swelling
____ Arthritis

Neurologic
____ Fainting Spell/Blacking Out
____ Disorientation
____ Numbness
____ Weakness
____ Speech Difficulty
____ Loss of Coordination
____ Facial Weakness
____ Stroke
____ Headache
____ Double or Blurred Vision

Psychiatric
____ Depression
____ Anxiety
____ Other Psych Disorder

Endocrine
____ Diabetes
____ Thyroid Problems
____ Excessive Thirst
____ Urinary Frequency
____ Other Hormone Issues

Hematologic
____ Anemia
____ Persistent Swollen Glands
____ Easy Bleeding/bruising