

## EAST ALABAMA EAR, NOSE AND THROAT, PC ADULT PATIENT HEALTH HISTORY

**TODAY'S DATE:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **YOUR PRIMARY CARE PHYSICIAN:** \_\_\_\_\_

**NAME:** \_\_\_\_\_

**AGE:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
First Middle Last

**GENDER:**  Female  Male **HEIGHT:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_

**WHO REFERRED YOU TO US?**

- Primary care physician  
 Other physician(s) Name: \_\_\_\_\_  
 Friend/family

**MAIN REASON FOR VISIT:**

Describe briefly: \_\_\_\_\_

How long have symptom(s) been present? \_\_\_\_\_

What makes it better or worse? \_\_\_\_\_

Have you seen other physicians about this problem?  Yes  No If Yes, when? \_\_\_\_\_

Have you taken any medications for this condition?  Yes  No If Yes, what kind? \_\_\_\_\_

Have you had any tests performed so far?  Yes  No If Yes, when? \_\_\_\_\_

What treatments/surgeries have you already had for this problem? \_\_\_\_\_

Do you have any of the following?

	YES	NO
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
Post nasal drip	<input type="checkbox"/>	<input type="checkbox"/>
Decreased smell/taste	<input type="checkbox"/>	<input type="checkbox"/>
Nose congestion	<input type="checkbox"/>	<input type="checkbox"/>
Frequent sore throat	<input type="checkbox"/>	<input type="checkbox"/>
Change in voice	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Decreased hearing	<input type="checkbox"/>	<input type="checkbox"/>
Ear infection	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Ringing ears (tinnitus)	<input type="checkbox"/>	<input type="checkbox"/>
Snoring	<input type="checkbox"/>	<input type="checkbox"/>
Lump in neck	<input type="checkbox"/>	<input type="checkbox"/>

**MEDICATION:**

Do you take the following? **YES NO**

	YES	NO
Coumadin/warfarin	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin/BC powder	<input type="checkbox"/>	<input type="checkbox"/>
Plavix	<input type="checkbox"/>	<input type="checkbox"/>
Ibuprofen/Advil/Motrin	<input type="checkbox"/>	<input type="checkbox"/>
Aleve/Naprosyn	<input type="checkbox"/>	<input type="checkbox"/>
Ginkgo biloba	<input type="checkbox"/>	<input type="checkbox"/>
Vitamin E	<input type="checkbox"/>	<input type="checkbox"/>

List all other medication(s) you currently take including over the counter and herbal supplements (you may provide a separate sheet if not enough space):

Name	Dose	Name	Dose

**ALLERGIES:**

**YES NO**

Are you allergic to latex?	<input type="checkbox"/>	<input type="checkbox"/>
Are you allergic to tape?	<input type="checkbox"/>	<input type="checkbox"/>
Are you allergic to iodine?	<input type="checkbox"/>	<input type="checkbox"/>
Are you allergic to IV contrast?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had allergy testing?	<input type="checkbox"/>	<input type="checkbox"/>

List all medications you are allergic to and their reaction(s):

Name	Reaction(s)	Name	Reaction(s)

**PREVIOUS SURGERIES:**

SURGERY (check if applies to you)	DATE(S)	OTHER SURGERY (please list below)	DATE(S)
<input type="checkbox"/> Tonsillectomy			
<input type="checkbox"/> Adenoidectomy			
<input type="checkbox"/> Ear tubes			
<input type="checkbox"/> Nasal Surgery (septoplasty)			
<input type="checkbox"/> Sinus Surgery			
<input type="checkbox"/> Mastoid Surgery			
<input type="checkbox"/> Palate Surgery			
<input type="checkbox"/> Pacemaker placement			
<input type="checkbox"/> Heart bypass surgery			

**PAST MEDICAL HISTORY:**

Please check if you are currently being treated or been diagnosed for any of the following conditions:

	YES	NO		YES	NO
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes – diet controlled	<input type="checkbox"/>	<input type="checkbox"/>
Past heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes – oral medication	<input type="checkbox"/>	<input type="checkbox"/>
Blocked heart arteries	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes – insulin shots	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid cancer	<input type="checkbox"/>	<input type="checkbox"/>
Heartbeat irregularity	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid nodule	<input type="checkbox"/>	<input type="checkbox"/>
Heart failure	<input type="checkbox"/>	<input type="checkbox"/>	Overactive thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Low thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>
COPD (chronic lung disease)	<input type="checkbox"/>	<input type="checkbox"/>	Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Allergic rhinitis	<input type="checkbox"/>	<input type="checkbox"/>
Acid reflux	<input type="checkbox"/>	<input type="checkbox"/>	Food allergy	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>
Hiatal hernia	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Past stroke	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	HIV positive	<input type="checkbox"/>	<input type="checkbox"/>
Neurological disease	<input type="checkbox"/>	<input type="checkbox"/>	Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Cataract	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	TMJ	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>			

If you are female, are you currently pregnant?  YES  NO

Other unlisted disease(s): \_\_\_\_\_

If you have been treated for any type of cancer, please give details: \_\_\_\_\_

**REVIEW OF SYSTEMS:**

	YES	NO		YES	NO		YES	NO
Unplanned weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Light bothers eyes	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Recent fevers/chills	<input type="checkbox"/>	<input type="checkbox"/>	Vision changes	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination	<input type="checkbox"/>	<input type="checkbox"/>
Facial rashes	<input type="checkbox"/>	<input type="checkbox"/>	Itchy/watery eyes	<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>
Itchy skin	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent headaches	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Facial numbness	<input type="checkbox"/>	<input type="checkbox"/>	High stress	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Shaking/tremors	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	Daytime sleepiness	<input type="checkbox"/>	<input type="checkbox"/>
Coughing blood	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Trouble concentrating	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>
Heat intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Foot/ankle swelling	<input type="checkbox"/>	<input type="checkbox"/>	Frequent thirst	<input type="checkbox"/>	<input type="checkbox"/>

**FAMILY HISTORY:**

Check box(es) if any of the following affects your immediate blood relatives (parents, siblings, children):

- Heart disease       Bleeding problem       High blood pressure       Stroke
- Cancer       Allergies       Hearing loss       Asthma
- Thyroid problem       Diabetes       Sickle cell       Other: \_\_\_\_\_

If you checked any of the boxes above, please give more detail if known: \_\_\_\_\_

**SOCIAL HISTORY:**

Please check box and provide details when indicated for the following questions:

- Do you smoke tobacco?     **YES**       **NO**
- How many packs per day? \_\_\_\_\_
- How many years have you smoked? \_\_\_\_\_
- Did you smoke in the past?  YES     NO
- If yes, how long? \_\_\_\_\_
- If yes, when did you quit? \_\_\_\_\_
- If yes, how many packs per day? \_\_\_\_\_
- 
- Do you drink alcohol?     **YES**       **NO**
- How often? \_\_\_\_\_
- How much? \_\_\_\_\_
- Use in the past?  YES     NO
- If yes, when did you quit? \_\_\_\_\_

Have you been or currently exposed to loud noises (firearms, machines, etc)?  YES     NO

Do you regularly sing, scream, or yell?  YES     NO

Do you drink more than one serving of a caffeinated beverage a day?  YES     NO

Have you used chewing tobacco in the present or past?  YES     NO

Have you used illicit drugs in the past year?  YES     NO

**I believe that the above information is completed to the best of my knowledge:**

Patient signature: \_\_\_\_\_

Physician signature: \_\_\_\_\_