TODAY'S DATE: _____

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PATIENT HISTORY FORM

PATIENT – *LAST NAME:*_____ *FIRST NAME:*_____ *M.I.:*____ *AGE:*_____

□ MALE □ FEMALE DATE OF BIRTH:_____ WHO REFERRED YOU TO US?_____

HAS ANYONE IN YOUR FAMILY BEEN SEEN HERE BEFORE? □ YES □ NO IF SO, WHO & WHY?_____

REASON FOR TODAY'S VISIT:_____

PRIOR SURGERIES:_____

DRUG ALLERGIES:_____

MEDICAL ILLNESSES:_____

PLEASE LIST CURRENT MEDICATIONS: _____ _____ _____

_____ _____ _____ _____

BLEEDING OR ANESTHESIA PROBLEMS? □ YES □ NO IF YES, PLEASE EXPLAIN:_____

DO YOU SMOKE? □ YES □ NO AMOUNT:_____ DID YOU EVER SMOKE? □ YES □ NO AMOUNT:_____

DO YOU DRINK ALCOHOL? □ YES □ NO AMOUNT:_____ DID YOU EVER DRINK ALCHOHOL? □ YES □ NO AMOUNT:_____

FAMILY HISTORY OF: □ CANCER □ BLEEDING DISORDER □ HEARING LOSS □ DIABETES PREGNANT? □ YES □ NO

BIRTH HISTORY (IF CHILD): WEEKS GESTATION_____ TIME IN NICU_____ WAS CHILD EVER ON A VENTILATOR?____

ARE YOU CURRENTLY EXPERIENCING: (CHECK ALL THAT APPLY)

EAR:	HEARING LOSS	□ YES	□ NO
	VERTIGO OR DIZZINESS	□ YES	□ NO
	UNSTEADINESS	□ YES	□ NO
	HEAD NOISE OR TINNITUS	□ YES	□ NO
	EAR PAIN	□ YES	□ NO
	EAR DRAINAGE	□ YES	□ NO
	EAR PRESSURE	□ YES	□ NO
	NOISE EXPOSURE	□ YES	□ NO
	WEAR HEARING AID(S)	□ YES	□ NO
NOSE:	BLEEDING	□ YES	□ NO
	RUNNY NOSE	□ YES	□ NO
	SNEEZING	□ YES	□ NO
	ITCHY NOSE	□ YES	□ NO
	POST NASAL DRIP	□ YES	□ NO
	HEADACHES	□ YES	□ NO
	FACIAL PRESSURE	□ YES	□ NO
	NASAL OBSTRUCTION	□ YES	□ NO
THROAT:	SWALLOWING DIFFICULTY	□ YES	□ NO
	THROAT PAIN	□ YES	□ NO
	REGURGITATION	□ YES	□ NO
	HOARSENESS	□ YES	□ NO
	COUGH	□ YES	□ NO
	COUGHING BLOOD	□ YES	□ NO
	SWOLLEN NECK GLANDS	□ YES	□ NO
	SNORING	□ YES	□ NO
	BREATHING CESSATION DURING SLEEP	□ YES	□ NO

GENERAL: (if yes, please explain below)

HEART TROUBLE	□ YES	□ NO
CHEST PAIN/ANGINA PECTORIS	□ YES	□ NO
SHORTNESS OF BREATH	□ YES	□ NO
ABDOMINAL PAIN OR HEARTBURN	□ YES	□ NO
NAUSEA OR VOMITING	□ YES	□ NO
STROKE	□ YES	□ NO
HEAD INJURY	□ YES	□ NO
THYROID DISEASE	□ YES	□ NO
HIGH OR LOW_____		
PAST TRANSFUSION	□ YES	□ NO
BLEEDING OR BRUISING TENDENCY	□ YES	□ NO
ARTHRITIS	□ YES	□ NO
DIABETES	□ YES	□ NO
RISK FACTORS FOR HIV/AIDS	□ YES	□ NO
FATIGUE	□ YES	□ NO
WEIGHT LOSS	□ YES	□ NO
PSYCHIATRIC ISSUES	□ YES	□ NO
LIVER PROBLEMS/DISEASE	□ YES	□ NO
ALLERGY/IMMUNE DISORDERS	□ YES	□ NO
BLOOD DISORDERS	□ YES	□ NO
NEUROLOGICAL PROBLEMS	□ YES	□ NO
HISTORY OF CANCER	□ YES	□ NO

EXPLAIN ANY YES ANSWERS:_____

_____

_____

_____

STATEMENT: "I HAVE COMPLETED THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE AND BELIEVE IT TO BE TRUE."

SIGNATURE:_____ DATE:_____

NAME OF PERSON FILLING OUT FORM:_____ RELATIONSHIP TO PATIENT:_____

► ***(FOR PHYSICIAN/OFFICE USE ONLY)***

HISTORY OF PRESENT ILLNESS:

LOCATION:_____ QUALITY:_____

SEVERITY:_____ TIMING:_____

DURATION:_____ CONTEXT:_____

MODIFYING FACTORS:_____

ASSOCIATED SIGNS & SYMPTOMS:_____