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PATIENT HISTORY FORM

| PATIEN | NT – <i>LAST NAME:</i> | | FIRST NAME:M.I.: | AGE: |
|---|---|--|--|----------------------------|
| | | | WHO REFERRED YOU TO US? | |
| | | | ORE? ¬YES NO IF SO, WHO & WHY? | |
| | | | | |
| | | | | |
| PRIOR | SURGERIES: | | | |
| DRUG . | ALLERGIES: | | | |
| MEDIC | AL ILLNESSES: | | | |
| | | | | |
| | | | - | |
| BLEED | ING OR ANESTHESIA PROBL | EMS? □ YES □ NO | IF YES, PLEASE EXPLAIN: | |
| DO YOU SMOKE? YES NO AMOUNT: | | | _ DID YOU EVER SMOKE? □ YES □ NO AMOUNT: | |
| DO YO | U DRINK ALCOHOL? □ YES □ | NO AMOUNT: | _ DID YOU EVER DRINK ALCHOHOL? □ YES □ NO A | .MOUNT: |
| FAMIL | Y HISTORY OF: □ CANCER | □ BLEEDING DISO | RDER □ HEARING LOSS □ DIABETES PREGNA | NT? □ YES □ NC |
| RIRTH | HISTORY (IF CHII D): WEEKS | S GESTATION | TIME IN NICU WAS CHILD EVER ON A VE | NTILATOR? |
| | | | | 1\11L1\11\0\(\ |
| ARE YO EAR: | <u>OU CURRENTLY EXPERIENC</u> HEARING LOSS | <u>ING: (CHECK ALL T</u> □ YES □ NO | <u>(HAT APPLY)</u> GENERAL: (if yes, please explain | , halow) |
| EAK. | VERTIGO OR DIZZINESS | | HEART TROUBLE | □ YES □ NO |
| | VERTIGO OR DIZZINESS UNSTEADINESS | | CHEST PAIN/ANGINA PECTORIS | |
| | HEAD NOISE OR TINNITUS | | SHORTNESS OF BREATH | □ YES □ NO |
| | EAR PAIN | | ABDOMINAL PAIN OR HEARTBURN | |
| | EAR DRAINAGE | | NAUSEA OR VOMITING | |
| | EAR PRESSURE | | STROKE | |
| | | | | |
| | NOISE EXPOSURE | □ YES □ NO | HEAD INJURY | □ YES □ NO |
| | WEAR HEARING AID(S) | | TH TROID DISEASE | □ YES □ NO |
| <u>NOSE:</u> | | \square YES \square NO | HIGH OR LOW | |
| | RUNNY NOSE | \square YES \square NO | PAST TRANSFUSION | \square YES \square NO |
| | SNEEZING | \square YES \square NO | BLEEDING OR BRUISING TENDENCY | \square YES \square NO |
| | ITCHY NOSE | \square YES \square NO | ARTHRITIS | \square YES \square NO |
| | POST NASAL DRIP | \square YES \square NO | DIABETES | \square YES \square NO |
| | HEADACHES | \square YES \square NO | RISK FACTORS FOR HIV/AIDS | \square YES \square NO |
| | FACIAL PRESSURE | □ YES □ NO | FATIGUE | □ YES □ NO |
| | NASAL OBSTRUCTION | \sqcap YES \sqcap NO | WEIGHT LOSS | □ YES □ NO |
| | | | PSYCHIATRIC ISSUES | □ YES □ NO |
| <i>THROAT:</i> SWALLOWING DIFFICULTY □ YES □ NO | | | LIVER PROBLEMS/DISEASE | □ YES □ NO |
| | THROAT PAIN | | ALLERGY/IMMUNE DISORDERS | |
| | REGURGITATION | | RI OOD DISORDERS | |
| | HOARSENESS | | BLOOD DISORDERS NEUROLOGICAL PROBLEMS | |
| | | | HISTORY OF CANCED | |
| | COUGH COUGHING BLOOD SWOLLEN NECK GLANDS SNORING | | HISTORY OF CANCER EXPLAIN ANY YES ANSWERS: | LIES LINU |
| | | □ IES □ NO | | |
| | SWORING | □ IES □ NU | | |
| | SNORING BREATHING CESSATION DI | □ YES □ NO JRING SLEEP □ | YES NO | |
| • | | | ATION TO THE BEST OF MY KNOWLEDGE AND BELIEVE IT T | |
| | | | DATE: | |
| | | | | |
| | (FOR PHYSICIAN/OFFICE | | | ·• |
| | • | , | HISTORY OF PRESENT ILLNESS:QUALITY: | |
| SEVER | ITY: | | TIMING: | |
| DITRAT | LION. | | CONTEXT: | |
| MODIE | YING FACTORS: | | CONTEXT | |
| ASSOC | TATED SIGNS & SYMPTOMS: | | | |