Please answer this questionnaire to the best of your knowledge. Information is confidential and will be used by the care providers of The Ear, Nose and Throat Clinic & Hearing Center to evaluate and treat your medical problems.

THE EAR, NOSE AND THROAT CLINIC & HEARING CENTER

Adult Medical History Form

Please print (if you do not understand a question, leave it blank)

Today's date _____

PATIENT NAME _____
(First) (M) (Last) (Date of birth)

Name of your regular physician: _____ Clinic: _____

1. CHRONIC MEDICAL PROBLEMS (high blood pressure, high cholesterol, diabetes, etc.)

_____

_____

2. PRIOR SURGERIES

_____Date _____ _____ Date _____

_____Date _____ _____ Date _____

3. BLOOD CONDITIONS

a. Have you had hepatitis? No ____ Yes ____ Date _____ b. Have you been tested for HIV? No ____ Yes ____ Results (optional) ____

c. Have you had a blood transfusion? No ____ Yes ____ Date _____ d. Do you have blood clotting or bruising problems? No ____ Yes ____

4. MEDICATIONS

a. Are you currently taking any prescription medications? No ____ Yes ____ Please list: _____

_____

b. Are you currently taking any over-the-counter medications? No ____ Yes ____ Please list: _____

_____

5. ALLERGIES

a. Are you allergic to any medications? No ____ Yes ____ Please list: _____

b. Do you have environmental allergies/hay fever? No ____ Yes ____ c. Have you been tested for allergies? No ____ Yes ____

d. Do you have food sensitivities? No ____ Yes ____ Which foods? _____

e. Other allergies? _____

6. Do you smoke? No ____ Yes ____ How many packs per day for how many years? _____ If you quit, when? _____

7. Do you drink alcoholic beverages? No ____ Yes ____ How many drinks per week? _____ Or month? _____

8. FAMILY HISTORY

Mother living No ____ Yes ____ Died of: _____ Father living No ____ Yes ____ Died of: _____

Family history of ear or hearing problems? No ____ Yes ____ Details: _____

Family history of allergy? No ____ Yes ____ Details: _____

9. REVIEW OF SYSTEMS Please circle any symptoms you currently have

GENERAL:		RESPIRATORY:		GASTROINTESTINAL:	
Unexplained fevers/night sweats	Y / N	Persistent cough	Y / N	Nausea/vomiting	Y / N
Unintentional weight loss	Y / N	Hoarseness	Y / N	Heartburn/acid reflux	Y / N
SKIN:		Shortness of breath	Y / N	EYES:	
Change in moles	Y / N	MUSCLE/JOINT/BONE:		Blurred vision	Y / N
Sore that won't heal	Y / N	Pain, weakness or numbness in:		Double vision	Y / N
ENT:		Arms/legs	Y / N	HEME/LYMPH:	
Difficulty swallowing	Y / N	Back/neck	Y / N	Enlarged lymph nodes	Y / N
Ear pain/drainage	Y / N	NEUROLOGIC:		Excessive bleeding	Y / N
Nosebleeds	Y / N	Headache	Y / N	CARDIO	
Hearing loss	Y / N	Numbness/tingling	Y / N	Chest pain	Y / N
Ringing in ears	Y / N	ALLERGY/IMMUNO:		Irregular heartbeat	Y / N
Sinus problems	Y / N	Decreased immunity	Y / N	Heart murmur	Y / N
		Hay fever	Y / N		

Physician use only: Date/Initials _____