

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

Physician use only: Date/Initials _____