

East Tennessee Ear, Nose and Throat Specialists, PC

Patient Health History Form

Today's Date: _____

Patient's Name: _____ DOB: _____ Male Female

Person Completing this form: Patient Mother Father Other _____

MEDICAL INFORMATION: Reason for seeing the doctor: _____

Height: _____ Weight: _____

MEDICATIONS: Please list any prescription, over-the-counter or herbal medications that you are currently taking.

Name of Medication	Strength (mg, etc)	Dose (how much/day)	Reason for taking medication

ARE YOU ALLERGIC to ANY MEDICATION? **N** **Y** If yes, please list below.

Name of Medication	Type of reaction (nausea, hives, etc.)

NON - MEDICATION ALLERGIES: Please check any of the following that you are **ALLERGIC** to:

- | | | |
|----------------------|---------------------|-------------|
| Adhesive tape | Metal | |
| Iodine | Seafood | |
| Latex | Contrast Dye | None |

PAST HEALTH: Please check if you have ever been **DIAGNOSED** with any of the following:

- | | | | | | |
|-----------------|--------------------|---------------------|-------------------------|---------------------|------------|
| Breast Cancer | Migraine Headaches | High Cholesterol | Tuberculosis | Stroke | Hemophilia |
| Lung Cancer | Cataracts | Heart Attack | Hepatitis | Anxiety | HIV |
| Skin Cancer | Glaucoma | High Blood Pressure | Gastrointestinal Reflux | Depression | Other |
| Throat Cancer | Nasal Allergies | Asthma | Stomach Ulcer | Diabetes | |
| Prostate Cancer | Sleep Apnea | Chronic Bronchitis | Prostate Enlargement | Thyroid Dysfunction | |
| Other Cancer | Blood Clots/DVT | Emphysema | Renal Failure | Anemia | |

(For Women) Are you Pregnant? **N** **Y**

SURGERIES AND HOSPITALIZATIONS: Have you ever had any problems with **ANESTHESIA**? **N** **Y**

If yes, please list what sort of **problems**: _____

Please list any **surgeries** you have had and the date of the surgery.

Have you been HOSPITALIZED for a MEDICAL ILLNESS? **N** **Y** If yes, list hospitalizations, the reason for admission, and the approximate date(s) of admission _____

FAMILY HISTORY: Has anyone in your immediate family had any of the following problems? Please place a **X** in any box that applies.

	Mother	Father	Brother	Sister	Child		Mother	Father	Brother	Sister	Child
Slow to wake up from anesthesia						Lung Cancer					
Migraine Headaches						Stroke					
Hearing loss						Diabetes					
Chronic Sinus Disease						Bleeding/clotting problems					
High Blood Pressure						NONE					
Asthma											

SOCIAL HISTORY

Are you retired **N** **Y**? What is or was your occupation? _____

Have you ever used tobacco in any form? **N** **Y** If yes, please complete the following:

Type of Tobacco -	From year:	To year:
Cigarettes per day:		
Other: (list type)		

Have you ever used alcohol in any form? **N** **Y** If yes, please complete the following:

Type of Alcohol	From year:	To year:
Beers per week:		
Wine glasses per week:		
Other: (list type)		

Are you exposed to second-hand smoke? **N** **Y**

REVIEW OF SYSTEMS: Please check any of the following that you now have or have recently had:

Fatigue	Painful Eye	Mouth Ulcer	Shortness of Breath	Stiffness in Joints	Masses (lumps) in Armpits
Sleeping Problems	Ear Drainage	Partials or Dentures	Wheezing	Swelling of Joints	Masses (lumps) in Neck
Unintentional Weight loss	Hearing Loss	Blacking Out or Fainting	Abdominal Pain	Change in Sense of Smell	Masses (lumps) in Groin
Unintentional Weight gain	Ear Pain	Chest pain	Diarrhea	Change in Sense of Taste	Hives
Dizziness	Ringing in Ears	Heart Murmur	Heartburn	Seizures	Sneezing
Frequent Headache	Nasal Congestion	Irregular Heartbeats	Nausea	Tremor	
Severe Face Pain	Frequent Nosebleeds	Leg Cramps	Trouble Swallowing	Increased Appetite	
Blurred Vision	Post-Nasal Drainage	Swelling of Ankles	Painful Swallowing	Cold Feeling	
Itchy eyes	Belching Sour Mat'l into Throat	Frequent Non-Productive Cough	Vomiting	Bleed Excessively after Injury	
Loss of Vision	Hoarseness or other Voice Chg.	Frequent Productive Cough	Painful Joints	Bruise Easily	

For Office Use Only

Reviewed by Dr.: _____

Date: _____

Extracted to AllMeds by: _____