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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 ALCOHOL? 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)

LOCATION: _____ HISTORY OF PRESENT ILLNESS: _____

SEVERITY: _____ QUALITY: _____

DURATION: _____ TIMING: _____

MODIFYING FACTORS: _____ CONTEXT: _____

ASSOCIATED SIGNS & SYMPTOMS: _____