ENT & ALLERGY ASSOCIATES P.S.

Medical History

Patient Name _____ What is the reason for your visit today? _____
Patients name printed

Findings/Diagnosis _____

Date of last doctors visit: _____ Physician: _____

EARS, NOSE & THROAT SYMPTOMS NOW PRESENT: (PLEASE CHECK ALL THAT APPLY)

- ☐ Ear Infection
- ☐ Dizziness
- ☐ Recurring Sore Throat
- ☐ Swallowing Difficulty
- ☐ Nasal Blockage
- ☐ Enlarged Glands
- ☐ Coughing Up Blood
- ☐ Other: _____
- ☐ Draining from Ears
- ☐ Hearing Loss/Decreased Hearing
- ☐ Strep Throat
- ☐ Sore in Mouth
- ☐ Sinus Trouble
- ☐ Strange Odor or Taste
- ☐ Bleeding Gums
- ☐ Other: _____
- ☐ Ringing Ears
- ☐ Vertigo
- ☐ Hoarseness
- ☐ Nosebleeds
- ☐ Hay Fever
- ☐ Cough
- ☐ Growth in Neck/Throat
- ☐ Other: _____

PERSONAL HISTORY OF PATIENT: (PLEASE CHECK ALL THAT APPLY)

- ☐ Bleeding Problem
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Jaundice
- ☐ Heart Condition
- ☐ Nephritis (Kidney Problems)
- ☐ High Blood Pressure
- ☐ Problem with General Anesthesia
- ☐ Nervous Disorder
- ☐ Venereal Disease
- ☐ TB
- ☐ Other: _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____

Do you smoke? ☐ Yes ☐ No If yes, how much? _____

FAMILY HISTORY & BLOOD RELATIVES: (PLEASE CHECK ALL THAT APPLY)

- ☐ Asthma
- ☐ TB
- ☐ Suicide
- ☐ Bleeding Disorder
- ☐ Hay Fever
- ☐ Stroke
- ☐ Mental Illness
- ☐ Problem with General Anesthesia
- ☐ Diabetes
- ☐ Heart Condition
- ☐ Hearing Loss
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Epilepsy/Seizure Disorder
- ☐ Other health problems in the family: _____

ALLERGIES (PLEASE CHECK ALL THAT APPLY)

- ☐ Penicillin
- ☐ Sulfa
- ☐ Codeine
- ☐ Morphine
- ☐ Aspirin
- ☐ Medicated
- ☐ Bees
- ☐ Pollen
- ☐ Other: _____

LIST ALL OPERATIONS/HOSPITALIZATIONS (USE BACK OF PAGE IF NECESSARY)

Type/Date/Age _____ Physician _____

Type/Date/Age _____ Physician _____

Type/Date/Age _____ Physician _____

Were you ever advised to have an operation that was not performed? ☐ Yes ☐ No

Please list any medication you are now taking (sleeping pills, nose sprays, ear or eye drops, tranquilizers, aspirin, cortisone, vitamins etc.)

_____

_____

X _____ _____
Signature of patient or parent/guardian is minor Date

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