ENT Associates

ADULT HISTORY

Name _____ Date _____

Occupation _____ Age _____ ☐ M ☐ F

Referring Doctor _____ Primary Care Doctor _____

Reason for Visit: _____

Past Medical History: Please check if you have or have had problems with the following (where appropriate, indicate your specific diagnosis):

☐ **Diabetes** (sugar) ☐ **High Blood Pressure** ☐ **Heart** (diagnosis _____)

☐ **Lung** (diagnosis _____) ☐ **Kidneys** (diagnosis _____)

☐ **Neurologic** (diagnosis _____) ☐ **Cancer** (type _____)

☐ **GERD** (acid reflux) ☐ **Stroke** ☐ **HIV/AIDS** ☐ **Liver** (diagnosis _____)

☐ **Thyroid disorders** (diagnosis _____) OTHER: _____

Previous Surgery (please list) _____

Drug Allergies (please list) _____

Environmental Allergies (please list) _____

Previous allergy testing? ☐ Yes ☐ No (Date tested _____) **Allergy shots?** ☐ Yes ☐ No

Alcohol: ☐ Yes ☐ No How much _____ per day? Recovering alcohol dependent? ☐ Yes ☐ No Age quit _____

Recreational Drug Use: ☐ Yes ☐ No Type _____ How Long? _____ Age quit _____

Smoking/Tobacco: ☐ Yes ☐ No How much _____ per day? How old when started? _____ Age quit _____

Review of Systems: Please indicate yes or no, if you have any of the following symptoms:

General

Fatigue	☐ Yes ☐ No
Weight Gain	☐ Yes ☐ No
Fever	☐ Yes ☐ No
Weight Loss	☐ Yes ☐ No

Eyes

Blurred vision	☐ Yes ☐ No
Double vision	☐ Yes ☐ No

Ear, Nose, & Throat

Hearing Loss	☐ Yes ☐ No
Ear Drainage	☐ Yes ☐ No
Difficulty Swallowing	☐ Yes ☐ No
Nose Congestion	☐ Yes ☐ No
Tinnitus/Ear Ringing	☐ Yes ☐ No
Ear Pain	☐ Yes ☐ No
Painful Swallowing/Sore Throat	☐ Yes ☐ No
Nose Bleeds	☐ Yes ☐ No
Dizzy/Balance Problems	☐ Yes ☐ No
Noise Exposure	☐ Yes ☐ No
Hoarseness	☐ Yes ☐ No

Cardiovascular

Chest Pain	☐ Yes ☐ No
Irregular Heartbeats	☐ Yes ☐ No

Respiratory

Shortness of Breath	☐ Yes ☐ No
Cough	☐ Yes ☐ No
Cough with Blood	☐ Yes ☐ No

Gastrointestinal

Heartburn	☐ Yes ☐ No
Indigestion	☐ Yes ☐ No
Irritable Bowel	☐ Yes ☐ No

Genitourinary

Prostate Problems	☐ Yes ☐ No
Urinating Problems	☐ Yes ☐ No

Skin

Rash	☐ Yes ☐ No
Itching	☐ Yes ☐ No
New Skin Lesions	☐ Yes ☐ No

Neurologic

Headache	☐ Yes ☐ No
Seizures	☐ Yes ☐ No

Musculoskeletal

Fibromyalgia	☐ Yes ☐ No
Joint Pain	☐ Yes ☐ No
Muscle Ache	☐ Yes ☐ No

Psychiatric

Depression	☐ Yes ☐ No
Suicide Attempt	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No

Hematologic

Easy Bleeding	☐ Yes ☐ No
Easy Bruising	☐ Yes ☐ No

Other: _____

OVER ➡

Family History: Has anyone in family had:

Pollen Allergies ☐ Yes ☐ No (Relation/Type) _____ Heart Disease ☐ Yes ☐ No (Relation/Type) _____

Menieres Disease ☐ Yes ☐ No (Relation/Type) _____ Diabetes (Sugar) ☐ Yes ☐ No (Relation/Type) _____

Complications from Anesthesia (Relation/Reaction) _____

Bleeding Problems ☐ Yes ☐ No (Relation/Type) _____ Hearing Loss ☐ Yes ☐ No (Relation/Type) _____

Migraine Headaches ☐ Yes ☐ No (Relation/Type) _____ Cancer ☐ Yes ☐ No (Relation/Type) _____

High Blood Pressure ☐ Yes ☐ No (Relation/Type) _____ Unknown: Family History of Adoption ☐ Yes ☐ No

*If no medications, please check here ☐ NONE

MEDICATION	**DOSAGE** (strength)	**TYPE** (pill, patch, injection, etc.)	**FREQUENCY** (how many times per day)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
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21.			
22.			