



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 _____)

Medications (Please list or attach a list) _____

Previous Surgery (please list) _____

Drug Allergies (please list) _____

Environmental Allergies (please list) _____

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

Family History: Has anyone in family had:

- | | | | | | |
|------------------------------|--|--------------------|--|---------------------|--|
| Diabetes (Sugar) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hearing loss | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bleeding Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Menieres Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer (Relation/type) _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

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

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

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

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

Gastrointestinal

- Heartburn Yes No
- Indigestion Yes No
- Irritable Bowel Syndrome Yes No

Genitourinary

- Prostate Problems Yes No
- Urinating Problems 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

Neurologic

- Headache Yes No
- Seizures Yes No

Eyes

- Blurred vision Yes No
- Double vision Yes No

Skin

- Rash Yes No
- Cancer Yes No

Lymphatic/Immune/Hematologic

- Anemia Yes No
- High Cholesterol Yes No
- Bleeding Problems Yes No

General

- Weight Loss Yes No
- Weight Gain Yes No
- Fatigue Yes No
- Fever Yes No

Ear, Nose, & Throat

- Hearing loss Yes No
- Tinnitus/Ear Ringing Yes No
- Dizzy/Balance Problems Yes No
- Ear Drainage Yes No
- Ear Pain Yes No
- Difficulty swallowing Yes No
- Painful swallowing Yes No
- Hoarseness Yes No
- Nose congestion Yes No
- Nose bleeds Yes No
- Noise exposure Yes No

Respiratory

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

Cardiovascular

- Chest Pain Yes No
- Palpitations/Arrhythmia Yes No

Other: _____