Otolaryngology/Head and Neck Surgery History Form:

Name_____ DOB ____/____/____ Date____/____/____

Address _____ Phone_____

Referring Provider _____ Referring Provider Clinic# _____

Emergency Contact

Name_____ Relationship to Patient_____

Phone _____

Chief Complaint/Reason for Visit

_____

_____

_____

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY (circle all that apply - please add any additional medical history)

Anxiety Bleeding Disorder Cancer COPD/Emphysema Depression Diabetes GERD Hearing loss
Heart Disease Hepatitis HIV/AIDS High blood pressure High cholesterol Skin Cancer Sleep Apnea
Stroke Thyroid disease Other: _____

_____

PAST SURGICAL HISTORY (circle all that apply - please add any additional surgical history)

Adenoidectomy Ear surgery (other than tubes) Esophagus surgery Facial cosmetic surgery
Head/Neck surgery Heart surgery Lung surgery Ear Tubes Nose surgery Sinus surgery
Thyroid surgery Tonsillectomy Other: _____

_____

MEDICATION (please list any medications you are currently taking including vitamins, supplements and over the counter medications.)

_____

_____

_____

_____

PLEASE CONTINUE TO OTHER SIDE

APPLY PATIENT LABEL HERE

MR

MEDICATION ALLERGIES (please list allergy and the reaction to that medication. Eg. Rash, hives, swelling)

_____

_____

_____

_____

SOCIAL HISTORY

Have you ever smoked? CURRENTLY PREVIOUSLY NO. When did you quit? _____

Have you ever used chewing tobacco? YES NO

If yes, how much? (packs or tins per day)_____ How many years? _____

Have you ever used recreational drugs? YES NO _____ If yes, describe_____

How much alcohol do you drink weekly?_____

Have you ever been a heavy drinker (more than 14 alcoholic beverages per week)? YES NO

If yes, how much were/are you drinking daily? _____ How many years? _____

How many caffeinated beverages do you drink daily? _____

Occupation (prior to retirement if you are retired) _____

FAMILY HISTORY

High blood pressure	High cholesterol	Diabetes	Skin Cancer	Other Cancer	Hearing loss
Thyroid problem	Sleep Apnea	Heart Disease	Heart Attack	Stroke	

Other:_____

Any problems with excessive bleeding or anesthesia related problems in you or your family members?

YES NO If yes, please describe _____

CURRENT REVIEW OF SYSTEMS (please circle all that apply to you NOT including those already mentioned)

Constitutional:	chills night sweats	unexpected weight changes		fevers	
ENT:	pain with swallowing	difficulty swallowing		voice changes	
Eyes:	visual disturbances				
Respiratory:	shortness of breath	emphysema	wheeze/asthma	discomfort breathing	chest tightness
Cardiovascular:	chest pain	irregular heart beat			
Gastrointestinal:	nausea	vomiting	diarrhea	constipation	reflux
Genitourinary:	blood in urine	kidney stone			
Musculoskeletal:	muscle pain	neck pain	back pain	arthritis	
Skin:	rash	cancer			
Neurologic:	headache	fainting	weakness	facial asymmetry	dizziness stroke
Hematologic:	easy bruising	easy bleeding			
Psychiatric:	anxiety	depression			

OFFICE USE ONLY: PHYSICAL EXAM

Weight _____ Height _____Temp _____ BP _____

Pulse _____ Resp Rate _____

Pain Assessment 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Description of Pain_____

APPLY PATIENT LABEL HERE

MR