EAR, NOSE and THROAT, Ltd. – Patient History Form *Today's Date:*_____

Patient Name:_____ **DOB**:_____ **ID#**:_____

B/P:_____ P:_____ R:_____ T:_____ // Wt:_____ Ht:_____
(Nurse to Record))

☐ **NONE** **ALLERGIES**

Medication Allergies	Type of Reaction		Other Allergies	Type of Reaction

☐ **NONE** **MEDICATIONS (Prescription, over-the-counter or herbal)**

Medication	Dose	How often		Medication	Dose	How often
1.				6.		
2.				7.		
3.				8.		
4				9.		
5.				10.		

What is the reason for your visit today?_____

_____

PAST MEDICAL HISTORY: ***(Please check all that apply)***

Cardiovascular: **YES**
Cardiovascular Disease: ☐
Elevated cholesterol (hyperlipidemia): ☐
High Blood Pressure (hypertension): (CQM) ☐

Metabolic / Endocrine:
Diabetes: ***Type*** **# I** **# II** ☐
Thyroid deficiency (hypothyroidism): ☐
Thyroid excess (hyperthyroidism): ☐

Pulmonary / Respiratory:
Asthma: (CQM if use Meds) ☐
COPD/Emphysema: ☐
Sleep Apnea: ☐
Tuberculosis: ☐

Digestive / GI:
Gastroesophageal Reflux / Heartburn: ☐
Hiatal Hernia: ☐

Neurologic:
Migraine: ☐
Stroke: ☐

Musculoskeletal:
Arthritis: ***Type*** ☐
Fibromyalgia: ☐
Fractures: ***Type*** ☐

Hematology: **YES**
Anemia: ☐
Hepatitis: ***Type*** ☐
HIV + / AIDS: ☐
Lupus: ☐
Mononucleosis: ☐
STD: ***Type*** ☐

Neoplasim (Cancer):
Cancer ***Type*** ☐

Genitourinary:
Kidney Stones (Nephrolithiasis): ☐
Prostate enlargement (Prostatitis): ☐
Benign Prostatic Hyperplasia (BPH) ☐
Renal Failure (acute): ☐

Psychiatric:
ADHD / ADD: ☐
Anxiety (adjustment disorder): ☐
Depression: ☐

Other:
Glaucoma: ☐
Cataracts: ☐

OVER

EAR, NOSE and THROAT, Ltd. – Patient History Form

ENT SPECIFIC SURGERY:

- ☐ **Ear Tubes (BMTT)** **Where / When** _____
- ☐ **Ear Surgery (Internal)** **Where / When** _____
- ☐ **Ear Surgery (External)** **Where / When** _____
- ☐ **Nasal Surgery** **Where / When** _____
- ☐ **Sinus Surgery** **Where / When** _____
- ☐ **Tonsils and /or Adenoids** **Where / When** _____

OTHER SURGERY:

What _____ **Where / When** _____

What _____ **Where / When** _____

What _____ **Where / When** _____

FAMILY HISTORY: Place the family member letter after the check box for each family member who has / had the condition:
Mother **(M)**, Father **(F)**, Brother **(B)**, Sister (**S),** Maternal Grandmother **(MGM)**, Maternal Grandfather **(MGF)**, Paternal Grandmother **(PGM)**, Paternal Grandfather **(PGF):**

Allergies	☐	_____	Cancer **Type**:_____	☐	_____
Hearing deficiency	☐	_____	Cancer **Type**:_____	☐	_____
CAD (Coronary Artery Disease)	☐	_____	Alzheimer's / Dementia	☐	_____
CVA (Stroke)	☐	_____	Migraines	☐	_____
Hypertension	☐	_____	ADD/ADHD	☐	_____
PVD (Peripheral Vascular Disease)	☐	_____	Alcoholism	☐	_____
Diabetes	☐	_____	Depression	☐	_____
Obesity	☐	_____	Mental illness	☐	_____
Asthma	☐	_____	Osteoarthritis	☐	_____
COPD	☐	_____	Bleeding Disorders	☐	_____

SOCIAL HISTORY:

Do you consume alcohol? ☐ **Yes** ☐ **No**

Tobacco Use? (13 years and older) ☐ **Yes** ☐ **No** ☐ **Former** ___Age Started ___Age Stopped

PEDIATRIC PATIENTS:

Exposed to second hand smoke? ☐ **Yes** ☐ **No**

Was this child Premature at Birth? ☐ **Yes** ☐ **No**

Attends Child Care / Pre School? ☐ **Yes** ☐ **No**

TO BE COMPLETED BY THE NURSE **– CQM Questions:**

HX of Hi B/P: controlled w/ Meds (checked B/P during visit) (18-85) - **Y**

Breast CA Screening (40-69) - **Y**

Flu Shot (50 - >) - **Y**

Cervical CA Screen (50-75) - **Y**

Colorectal screen (50-70) - **Y**

Use of Asthma Med (5-64) - **Y**

Pneumonia Shot (65 - >) - **Y**

Smoking Cessation (18 - >) screened for tobacco use and had intervention – **Y**

Screening for Fall Risk - **Y**

Nurseôs Initials:_____