East Tennessee Ear, Nose and Throat Specialists, PC

Patient Health History Form

Today's Date: _____

Patient's Name: _____ DOB: _____ ◯ Male ◯ Female

Person Completing this form: ◯ *Patient* ◯ *Mother* ◯ *Father* ◯ *Other*_____

MEDICAL INFORMATION: Reason for seeing the doctor: _____
Height: _____ *Weight:* _____

MEDICATIONS: Please list any prescription, over-the-counter or herbal medications that you are currently taking.

Name of Medication	Strength (mg, etc)	Dose (how much/day)	Reason for taking medication

ARE YOU ALLERGIC to *ANY MEDICATION*? ◯ **N** ◯ **Y** If yes, please list below.

Name of Medication	Type of reaction (nausea, hives, etc.)

NON - MEDICATION ALLERGIES- Please check any of the following that you are **ALLERGIC** to:

☐ **Adhesive tape** ☐ **Metal**
☐ **Iodine** ☐ **Seafood**
☐ **Latex** ☐ **Contrast Dye** ☐ **None**

PAST HEALTH: Please check if you have ever been ***DIAGNOSED*** with any of the following:

☐ Breast Cancer	☐ Migraine Headaches	☐ High Cholesterol	☐ Tuberculosis	☐ Stroke	☐ Hemophilia
☐ Lung Cancer	☐ Cataracts	☐ Heart Attack	☐ Hepatitis	☐ Anxiety	☐ HIV
☐ Skin Cancer	☐ Glaucoma	☐ High Blood Pressure	☐ Gastrointestinal Reflux	☐ Depression	☐ Other
☐ Throat Cancer	☐ Nasal Allergies	☐ Asthma	☐ Stomach Ulcer	☐ Diabetes	
☐ Prostate Cancer	☐ Sleep Apnea	☐ Chronic Bronchitis	☐ Prostate Enlargement	☐ Thyroid Dysfunction	
☐ Other Cancer	☐ Blood Clots/DVT	☐ Emphysema	☐ Renal Failure	☐ Anemia	

(For Women) Are you Pregnant? ◯ ***N*** ◯ ***Y***

SURGERIES AND HOSPITALIZATIONS: Have you ever had any problems with ***ANESTHESIA?*** ◯ **N** ◯ **Y**
If yes, please list what sort of **problems**: _____

Please list any ***surgeries*** you have had and the date of the surgery.
_____
_____

Have you been HOSPITALIZED for a MEDICAL ILLNESS? ◯ **N** ◯ **Y** If yes, list hospitalizations, the reason for admission, and the approximate date(s) of admission_____
_____

FAMILY HISTORY: Has anyone in your immediate family had any of the following problems? Please place a ***X*** *in any box that applies.*

	Mother	Father	Brother	Sister	Child		Mother	Father	Brother	Sister	Child
Slow to wake up from anesthesia						Lung Cancer					
Migraine Headaches						Stroke					
Hearing loss						Diabetes					
Chronic Sinus Disease						Bleeding/clotting problems					
High Blood Pressure						**NONE**					
Asthma											

SOCIAL HISTORY
Are you retired ◯ **N** ◯ **Y**? What is or was your occupation? _____

Have you ever used tobacco in any form? ◯ **N** ◯ **Y** If yes, please complete the following:

Type of Tobacco -	From year:	To year:
Cigarettes per day:		
Other: (list type)		

Have you ever used alcohol in any form? ◯ **N** ◯ **Y** If yes, please complete the following:

Type of Alcohol	From year:	To year
Beers per week:		
Wine glasses per week:		
Other: (list type)		

Are you exposed to second-hand smoke? ◯ **N** ◯ **Y**

REVIEW OF SYSTEMS: Please check any of the following that you now have or have recently had:

☐ Fatigue	☐ Painful Eye	☐ Mouth Ulcer	☐ Shortness of Breath	☐ Stiffness in Joints	☐ Masses (lumps) in Armpits
☐ Sleeping Problems	☐ Ear Drainage	☐ Partials or Dentures	☐ Wheezing	☐ Swelling of Joints	☐ Masses (lumps) in Neck
☐ Unintentional Weight loss	☐ Hearing Loss	☐ Blacking Out or Fainting	☐ Abdominal Pain	☐ Change in Sense of Smell	☐ Masses (lumps) in Groin
☐ Unintentional Weight gain	☐ Ear Pain	☐ Chest pain	☐ Diarrhea	☐ Change in Sense of Taste	☐ Hives
☐ Dizziness	☐ Ringing in Ears	☐ Heart Murmur	☐ Heartburn	☐ Seizures	☐ Sneezing
☐ Frequent Headache	☐ Nasal Congestion	☐ Irregular Heartbeats	☐ Nausea	☐ Tremor	
☐ Severe Face Pain	☐ Frequent Nosebleeds	☐ Leg Cramps	☐ Trouble Swallowing	☐ Increased Appetite	
☐ Blurred Vision	☐ Post-Nasal Drainage	☐ Swelling of Ankles	☐ Painful Swallowing	☐ Cold Feeling	
☐ Itchy eyes	☐ Belching Sour Mat'l into Throat	☐ Frequent Non-Productive Cough	☐ Vomiting	☐ Bleed Excessively after Injury	
☐ Loss of Vision	☐ Hoarseness or other Voice Chg.	☐ Frequent Productive Cough	☐ Painful Joints	☐ Bruise Easily	

For Office Use Only

Reviewed by Dr.:_____
Date: _____
Extracted to AllMeds by: _____