Welcome!

Otolaryngology Associates, P.C.

Medical History Form

Please complete all of this form and bring it with you to your office visit.

Patient's Name _____ Today's Date ___/___/___

Date of Birth ___/___/___ Gender ☐ Male ☐ Female

Who referred you here? _____ Phone _____

Name of Your Primary Care Physician _____ Phone _____

Your Preferred Pharmacy and City _____ Phone _____

REASON FOR THIS APPOINTMENT (HPI)

Primary Complaint/Symptom _____

Location: _____ Duration: _____

Severity: _____ Symptom Relieved when: _____

Related Symptoms: _____ Previous Diagnostic Testing: _____

MEDICINES

List all Prescription Medicines you take. Include oral medications, nasal sprays/steroids, and topical ointments.

Medication Name	Medical Condition	Dose (How much)	Frequency (How Often)

☐ Check here if you take no prescription medicines.

Check all NON-Prescription Medicine you take.

☐ Aspirin _____ mg ☐ Advil/Motrin/Nuprin (Ibuprofen) ☐ Naproxen ☐ Tylenol (Acetaminophen)

☐ Vitamin E ☐ Multi-Vitamin ☐ Cold/Allergy _____

☐ Other Vitamins/Supplements (list) _____ ☐ Herbals (list) _____

MEDICAL HISTORY

Please check any medical problems you have had: ☐ I have none of the below listed conditions and no known illnesses.

☐ Allergies/seasonal environmental
☐ Asthma
☐ COPD/Emphysema
☐ Bronchitis; Recurrent/ Chronic
☐ Obstructive Sleep Apnea/ CPAP Use
☐ Sinus infection, recurrent
☐ Anxiety
☐ Concussion
☐ Migraines/Headaches
☐ Mental Illness: specify_____
_____
☐ Neuromuscular Disease
☐ Seizures/Epilepsy
☐ Blood Thinners
☐ DVT/Blood Clots
☐ Heart Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ Peripheral Vascular Disease
☐ Stroke/TIA
☐ Autoimmune Disorder
☐ Bleeding Disorder
☐ Cancer
☐ Cataracts/Glaucoma
☐ Diabetes
☐ Gastroesophageal Reflux
☐ General Anesthesia/Previous Reactions
☐ Malignant Hyperthermia
☐ Hepatitis
☐ Hormonal Imbalance

MEDICAL HISTORY *continued*

☐ Kidney Problems
☐ Peptic or Gastric Ulcer
☐ **Pregnant Currently**
☐ Radiation Therapy
☐ Thyroid Problems
☐ Tuberculosis (TB)
☐ Chromosome Disorder
☐ Congenital Malformation
☐ Development Delay
☐ Premature Birth
☐ Other(s) not listed above (specify) _____

_____

ALLERGIES

Allergies to Medicine	Reaction	Environmental Allergies	Reaction

☐ Check here if no known allergies.

Are you allergic to latex? ☐ No ☐ Yes

SURGERIES

List all other surgeries, including plastic surgery and Lasik, and the month/year. ☐ Check here if none

- ☐ Adenoidectomy __/__
- ☐ Tonsillectomy __/__
- ☐ Ear Tubes __/__
- ☐ Ear Surgery __/__
- ☐ Nasal Surgery __/__
- ☐ Sinus Surgery __/__
- ☐ Abdomen Surgery __/__
- ☐ Brain Surgery __/__
- ☐ Breast Surgery __/__
- ☐ Facial Cosmetic Surgery __/__
- ☐ Facial Fracture Surgery __/__
- ☐ Heart Surgery __/__
- ☐ Larynx Surgery __/__
- ☐ Orthopedic Surgery __/__

Other (and year):_____

HOSPITALIZATIONS

List reason for hospitalization and the year. Do not include surgeries. Check here if none ☐ _____

_____

_____

_____

_____

FAMILY MEDICAL HISTORY

For your blood relatives, list medical conditions and their relationship to you. ☐ None

	Mother	Father	Sister	Brother	Daughter	Son	Other
Anesthesia Problems	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐	☐
Clotting Disorder	☐	☐	☐	☐	☐	☐	☐
Hearing Loss	☐	☐	☐	☐	☐	☐	☐
Heart Disease (<45 yrs)	☐	☐	☐	☐	☐	☐	☐
Cancer (Type?)	☐	☐	☐	☐	☐	☐	☐
Other (Specify)	☐	☐	☐	☐	☐	☐	☐
Alive? (Yes/No or N/A)	☐	☐	☐	☐	☐	☐	☐

Name _____ Date of Birth / /

PERSONAL AND SOCIAL HISTORY

Household and Family

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

☐ If patient under 18, specify parental marital status ☐ If parents divorced/separated, specify guardianship_____

Pets ☐ Yes ☐ No # Siblings _____

Employment (Check all that apply):

☐ Employed full-time ☐ Employed part-time Occupation _____

☐ Retired ☐ Disabled ☐ Unemployed ☐ Student ☐ Homemaker

If child, specify: Daycare ☐ Y ☐ N Pre-K ☐ Y ☐ N Grade _____

Tobacco and Alcohol

Do you use tobacco? ☐ Current Smoker ☐ Former Smoker ☐ Non-Smoker

(Check all that apply) ☐ Cigarettes ☐ Cigars ☐ Chew ☐ Pipe ☐ eCigarettes

How many cigarettes/cigars per day?_____

Second hand smoke exposure?_____

Do you drink alcohol? ☐ No, never drank ☐ No, but did in the past Year Quit_____

☐ Yes (Check all that apply) ☐ Beer ☐ Wine ☐ Mixed Drinks ☐ Straight Liquor/Shots

How many drinks do you have in the average week? _____

Have you ever used illegal drugs? ☐ No ☐ Yes

REVIEW OF SYSTEMS

Please check all of the following conditions you have.

GENERAL HEALTH (Constitutional) ☐ *None*

☐ Unintentional weight loss or gain ☐ Fever/Chills ☐ Fatigue/Tiredness

EYES ☐ *None*

☐ Vision changes (decreased acuity, blurry, blindness) ☐ Double vision ☐ Eye pain ☐ Dry eyes ☐ Itching/Burning ☐ Tearing/Discharge

EARS, NOSE, MOUTH AND/OR THROAT ☐ *None*

☐ Hearing loss
☐ Itchy ears
☐ Ear pain
☐ Feeling of fluid in ears
☐ Ear discharge or drainage
☐ Ringing/Buzzing sound in ears
☐ Dizziness
☐ Mass or lump in nose
☐ Loss of sense of smell
☐ Breathing difficulty
☐ Nasal discharge or drainage
☐ Nasal obstruction or blockage
☐ Nosebleeds
☐ Sneezing
☐ Mass or lump in throat or neck
☐ Difficulty swallowing
☐ Drooling
☐ Recurrent/Chronic sore throat
☐ Snoring
☐ "Stuffy" nose or congestion
☐ Mouth growth, ulcer
☐ Pronunciation difficulty
☐ Dental, gum, or mouth pain
☐ Dental problems/Poorly fitting dentures
☐ Voice changes/ Hoarseness
☐ Facial weakness
☐ Facial pain
☐ TMJ problems
☐ Other_____

HEART, VEINS, AND/OR ARTERIES (CARDIOVASCULAR) ☐ *None*

☐ Chest pain/Angina
☐ Leg pain with walking
☐ Leg pain at rest
☐ Swelling or fluid in legs
☐ Varicose veins
☐ Irregular heart beat
☐ Other_____

LUNGS (RESPIRATORY) ☐ *None*

☐ Shortness of breath
☐ Wheezing
☐ Coughing up blood
☐ Cough
☐ Other_____

REVIEW OF SYSTEMS *continued*

STOMACH, INTESTINES, GALLBLADDER, OR LIVER (GASTROINTESTINAL) ☐ *None*

☐ Decrease in appetite ☐ Nausea or vomiting ☐ Diarrhea or constipation
☐ Heartburn or reflux ☐ Food intolerance ☐ Other_____
☐ Indigestion ☐ Blood in stool _____

BONES, JOINTS, MUSCLES (MUSCULOSKELETAL) ☐ *None*

☐ Muscle weakness/fatigue ☐ Cramping ☐ Hip/knee problems ☐ Other_____
☐ Joint stiffness/pain ☐ Neck pain ☐ Bone fractures _____
☐ Back/spine problems which bone(s): _____
_____

SKIN (INTEGUMENTARY SYSTEM) ☐ *None*

☐ Rash ☐ Recent baldness
☐ History of cold sores ☐ Other_____

BRAIN AND/OR NERVES (NEUROLOGICAL) ☐ *None*

☐ Headaches ☐ Blackouts/Fainting ☐ Other_____
☐ Paralysis ☐ Tremors _____
☐ Numbness or tingling ☐ Sleep problems

PSYCHIATRIC ☐ *None*

☐ Insomnia (trouble sleeping) ☐ Feeling depressed ☐ Eating disorders
☐ Feeling anxious ☐ Cutting/Self-inflicted injuries ☐ Other_____
_____

HORMONES (ENDOCRINE) ☐ *None*

☐ Heat/cold intolerance ☐ Excessive thirst/hunger/urination ☐ Other_____
☐ Excessive sweating _____

KIDNEYS, BLADDER, GENITALS (GENITOURINARY) ☐ *None*

☐ Blood in urine ☐ Painful urination ☐ Other_____
☐ Difficulty passing urine ☐ Frequent urination _____
☐ Incontinence

BLOOD (HEMATOLOGIC/LYMPHATIC) ☐ *None*

☐ Problems with blood clots ☐ Easy bruising ☐ Bleeding too long (will not clot) ☐ Other_____

PHYSICIAN REVIEW WITH PATIENT

☐ No Past Medical Conditions

_____

_____

_____

_____

_____

_____

Physician's Signature Date