OTOLARYNGOLOGY
PATIENT HISTORY FORM

Patient Name: _____ **Date:** _____

Reason for Appointment: _____

_____

Referring Physician: _____ **Primary Physician** (if different): _____

List medication you take below

If you receive ALL of your medications from HIMG providers you can leave this section blank.

_____

List medication you're allergic to

_____

Office Use Only

T _____
P _____
W _____
BP _____
O2 _____

Past Medical History

Allergy History
- ☐ Y Allergies
- ☐ Y Prior Allergen Shots

Eye History
- ☐ Y Vision Problems
- ☐ Y Glaucoma
- ☐ Y Cataract

Cardiac History
- ☐ Y Congestive Heart Fail
- ☐ Y Heart Attack or Stents
- ☐ Y Irregular Heart Beat
- ☐ Y High Blood Pressure
- ☐ Y Cholesterol

Pulmonary History
- ☐ Y Asthma
- ☐ Y Emphysema / COPD

Heme / Onc History
- ☐ Y Bleeding Disorder
- ☐ Y Cancer

☐ Y Other

Gastrointestinal History
- ☐ Y Hepatitis
- ☐ Y Esophageal Reflux

Kidney/Bladder History
- ☐ Y Prostate Disorders
- ☐ Y Kidney Failure
- ☐ Y Kidney Stones

Endocrine History
- ☐ Y Diabetes
- ☐ Y Thyroid Disorders

Musculoskeletal History
- ☐ Y Osteoporosis
- ☐ Y Arthritis

Neurological History
- ☐ Y Seizures
- ☐ Y Stroke/TIA
- ☐ Y Depression
- ☐ Y Anxiety
- ☐ Y Migraine Headaches

ENT Surgical History

Ear Procedures
- ☐ Y Ear Tubes
- ☐ Y Tympanoplasty
- ☐ Y Mastoidectomy
- ☐ Y Stapedectomy
- ☐ Y Cochlear Implant

Nasal Procedures
- ☐ Y Septoplasty
- ☐ Y Sinus Surgery

Neck / Throat
- ☐ Y Tonsillectomy
- ☐ Y Adenoidectomy
- ☐ Y Thyroid Surgery

Social History

- ☐ Y ☐ N Current smoker
- _____ packs/day
- ☐ Y ☐ N alcohol use
- ☐ Y Occupation (list below)
- ☐ Y retired from work

Other Surgical History

☐ Y Other

Family History

☐ Y None	Father	Mother	Sibling	Son	Daughter
Cancer	☐ Y	☐ Y	☐ Y	☐ Y	☐ Y
Heart Disease	☐ Y	☐ Y	☐ Y	☐ Y	☐ Y
Stroke	☐ Y	☐ Y	☐ Y	☐ Y	☐ Y
Diabetes	☐ Y	☐ Y	☐ Y	☐ Y	☐ Y
Thyroid	☐ Y	☐ Y	☐ Y	☐ Y	☐ Y

Review of Systems

Systemic symptoms:
- ☐ Y ☐ N Weight loss (list amoun
- ☐ Y ☐ N Fever

Psychological symptoms:
- ☐ Y ☐ N Sleep disturbances

Eye symptoms continued:
- ☐ Y ☐ N Itching of the eyes

Cardiovascular symptoms:
- ☐ Y ☐ N Chest pain
- ☐ Y ☐ N Palpitations

Pulmonary symptoms:
- ☐ Y ☐ N Shortness of breath
- ☐ Y ☐ N Cough
- ☐ Y ☐ N Coughing up blood
- ☐ Y ☐ N Wheezing

Gastrointestinal symptoms:
- ☐ Y ☐ N Swallowing difficulty
- ☐ Y ☐ N Heartburn

Genitourinary symptoms:
- ☐ Y ☐ N Pain with urination

Neurological symptoms:
- ☐ Y ☐ N Lightheadedness
- ☐ Y ☐ N Dizziness
- ☐ Y ☐ N Spinning dizziness
- ☐ Y ☐ N Headache

Skin symptoms:
- ☐ Y ☐ N Rashes

Hematological symptoms:
- ☐ Y ☐ N Easy bleeding