ENT Associates Southwest
PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Patient's Last Name _____First _____ Date of Birth: ___/___/___

MEDICATIONS: Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc… Use the back of this form if you need more room and let us know that you wrote there.

☐ **I TAKE NO MEDICATIONS** **Please List Your PHARMACY of Choice/city_____**

Name of Medication	Dosage/ How Often Taken	Why are you taking this medication?

ARE YOU ALLERGIC TO ANY MEDICATION? ____ Yes ____ No. If yes, please list below:

Name of Medication	Type of Reaction

ANY other allergies

Inhalant allergies (please check all that apply)					Aromas of soaps and lotions		
	Air conditioning		Being indoors		Mold		Exercise
	Animal exposure		Being outdoors		Smoke and fumes		Perfumes
	Cut grass		Dust		Cigarette smoke		pollen

YES	NO		
		FOOD allergies	**What foods?**
		CONTACT allergies	**Circle: iodine, latex, metal, tape**
		Contrast agent (dye) allergy	**Type:**
		Insect bite or sting allergy	**Circle: Bee, Spider, Mosquito, Flea, Fly, Ant**

Have you had any of these?

	Allergy skin tests- when/where:		**Food allergy tests-**when/where:
	Allergy blood test- when/where:		**Allergy SHOTS-**where/how long?

Complete back page

SURGERIES AND HOSPITALIZATIONS.

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ____Yes ____No			
	Heart raced after shot of anesthetic		Persistent weakness or paralysis
	Hyperthermia (high fever) during surgery		Trouble breathing
	Hypothermia (severely decreased body temperature) during surgery		Trouble with intubation (with placement of breathing tube during surgery)
	Nausea / Vomiting		Very slow to wake up

List ALL the **SURGERIES** that you have had in your lifetime:

_____

_____

_____

Have you ever been hospitalized for non-surgical reasons that have been longer then 24 hours?							
	Asthma		CHF		Fever		Heart rhythm problems
	Anemia		Dehydration		Heart attack		High blood pressure
	Bleeding (septicemia)		Diabetes		Heart rhythm		Mental health treatment
	Blood infection		COPD		Pneumonia		Pregnancy/delivery
	Stroke		Substance abuse		Renal failure		
Have you had any serious injuries?							

Tests and Immunizations	**List the YEAR**	**NEVER HAD**
Last Influenza Vaccine		
65 and older- year of last Pneumonia Vaccine		
50yo-75yo- year of last COLONOSCOPY		
FOR FEMALE PATIENTS		
50-74yo- year of last MAMMOGRAM		
21-64yo- year of last PAP test		

Family History:

Unknown history/ Adopted [ ]

PARENTS AND SIBLINGS	Mother	Father	Sister(s)	Brother(s)
Cancer (list type under family member)				
Head and Face- Facial paralysis, Migraines				
Ears – chronic infections hearing loss Meniere's disease				
Nasal or Sinus issues- Chronic sinus disease or Nasal allergies				
Respiratory problems- Asthma, COPD				
Cardiovascular- Heart disease, hypertension, CHF				
Neurologic - Stroke or dementia				
Endocrine- Diabetes, thyroid disease				
ANY FAMILY MEMBER with bleeding or clotting issues? YES / NO				
ANY FAMILY MEMBER with ANESTHESIA problems? YES / NO				

SOCIAL HISTORY

Current tobacco use	**YES / NO**	**TYPE:**	**TYPE:**	**Amount per day**	**Started at age?**
Past (discontinued) use of Tobacco products	Yes / No	Age started?	TYPE: Age stopped?	Amount per day	
Current use of alcoholic beverages	NONE	Abstainer – less than 12 a year	Light drinker- 1-14 drinks a month	Social drinker- 4-14 drinks weekly	2 or more daily
Caffeine use	NONE	1 daily	2-3 daily	4 or more daily	
DO YOU HAVE EXPOSURE TO SECOND HAND SMOKE?					