Allergy
Ear Nose
& Throat INSTITUTE
EXCELLENCE SINCE 1992
"To God be the Glory"
4920 SW Lee Blvd. • Lawton, OK 73505 • (580) 536-8844

PATIENT HISTORY FORM (PHF)

GENERAL INFORMATION

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Patient's Name _____ Age_____ Sex_____ Date_____

A. **Chief Complaints** (Why you came to see the doctor today.) List each problem and when it started:

1) _____
2) _____
3) _____

Associated Symptoms (Problems which you think are related to your chief complaints.)

1) _____
2) _____
3) _____

PAST MEDICAL HISTORY

B. **Review of Systems** (Problem you currently have or have been diagnosed with in the past)
Please mark all boxes (No/Yes) and add details in blanks.

1) Constitutional

No Yes
☐ ☐ Weight Loss / Gain _____
☐ ☐ Chronic Fever _____
☐ ☐ Anesthetic Reaction_____
☐ ☐ Birth Complications _____
☐ ☐ Childhood Illness _____

2) Eyes

No Yes
☐ ☐ Visual Problems_____
☐ ☐ Double Vision_____

3) Head/Ear Nose and Throat

No Yes
☐ ☐ Ear Infections _____
☐ ☐ Ear Pain_____
☐ ☐ Hearing Loss _____
☐ ☐ Ringing in Ears _____
☐ ☐ Ear Drainage _____
☐ ☐ Dizziness _____
☐ ☐ Sinus Infections_____
☐ ☐ Smell & Taste Disorder _____
☐ ☐ Nasal Obstruction _____
☐ ☐ Nasal Polyps _____
☐ ☐ Nose Bleeds_____
☐ ☐ Dental Problems _____
☐ ☐ TMJ Syndrome_____
☐ ☐ Hoarseness _____
☐ ☐ Swallowing Problems_____
☐ ☐ Neck Mass/Swelling _____
☐ ☐ Snoring/Apnea _____
☐ ☐ Other _____

4) Cardiovascular

No Yes
☐ ☐ Rheumatic Fever _____
☐ ☐ Heart Problems _____
☐ ☐ Strokes/TIA's_____
☐ ☐ Irregular Heart Beat_____
☐ ☐ High Blood Pressure _____
☐ ☐ Chest Pain_____

5) Respiratory

No Yes
☐ ☐ Chronic Cough _____
☐ ☐ COPD / Asthma _____
☐ ☐ Shortness of Breath _____

6) Gastrointestinal

No Yes
☐ ☐ Stomach Ulcers _____
☐ ☐ Heartburn / Acid Reflux _____
☐ ☐ Hepatitis _____
☐ ☐ Hiatal Hernia _____
☐ ☐ Food Sensitivity_____

7) Genitourinary

No Yes
☐ ☐ Kidney Problems_____
☐ ☐ Kidney Infection _____

8) Musculoskeletal

No Yes
☐ ☐ Muscle / Joint Pain _____
☐ ☐ Back / Neck Pain_____

9) Integument

No Yes
☐ ☐ Skin Problems _____
☐ ☐ Skin Lesion _____

10) Neurologic

No Yes
☐ ☐ Head Injury_____
☐ ☐ Seizures _____
☐ ☐ Headaches_____
☐ ☐ Loss of Consiousness_____

11) Psychiatric

No Yes
☐ ☐ Emotional Disorder_____
☐ ☐ Attention Deficit Disorder_____
☐ ☐ PTSD _____

12) Endocrine

No Yes
☐ ☐ Diabetes _____
☐ ☐ Thyroid Disease_____

13) Hematologic - Lymphatic

No Yes
☐ ☐ Easy Bleeding / Bruising _____
☐ ☐ Cancer_____
☐ ☐ Enlarged Lymph Nodes_____
☐ ☐ Blood Disease _____

14) Allergic-Immunologic

No Yes
☐ ☐ Allergies_____
☐ ☐ Hay Fever _____
☐ ☐ Hives_____
☐ ☐ AIDS / HIV Positive _____

C. **Medical History** List medical illnesses, chronic conditions, hospitalizations and surgeries you have had.

	Diagnosis	Treatment	Doctor	Date of Diagnosis
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				

D. **Surgical History** List any surgeries that you have had. Have you been told to take antibiotics before surgery or dental work? ☐ Yes ☐ No

	Diagnosis	Treatment	Doctor	Date of Diagnosis
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				

E. **Current Medications** List all prescribed medications as well as all "over-the-counter" medications, vitamins, herbals and supplements.

	Name of Drug	Reason Taken	Dose / Duration	Date Started
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				

F. **Medication Reactions / Allergies** List each reaction which has occured. Latex Allergy? ☐ Yes ☐ No

Medication / Substance | Reaction | Date of Occurence

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

8) _____

9) _____

10) _____

G. **Family** Please mark all boxes and add details in blanks regarding health status or cause of death in immediate family.

- ☐ Heart Disease_____
- ☐ High Blood Pressure _____
- ☐ Diabetes_____
- ☐ Stroke_____
- ☐ Bleeding Disorder _____
- ☐ Anesthetic Reaction_____
- ☐ Deafness _____
- ☐ Allergy / Hay Fever _____
- ☐ Asthma _____
- ☐ Thyroid Disorder_____
- ☐ Kidney Disease _____
- ☐ Hereditary Diseases_____
- ☐ Cancer _____
- ☐ Other _____
- ☐ Other _____

H. **Social** List all that apply. Chemical / Mold Exposure? ☐ Yes ☐ No

Type | Duration | When Stopped

1) Tobacco Use_____

2) Alcohol Use _____

3) Street Drug Use _____

4) Current Employment_____

(see over)

Patient Signature _____ Nursing Review By_____Date_____

Reviewing Provider's Signature_____Date_____