Allergy Ear Nose & Throat INSTITUTE
EXCELLENCE SINCE 1992
"To God be the Glory"
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PATIENT HISTORY FORM

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GENERAL INFORMATION

Patient's Name_____Age_____Sex_____Date_____

Chief Complaints (Why you came to see the doctor today. List each problem and when it stated)

1) _____

2) _____

3) _____

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

1) _____

2) _____

3) _____

PAST MEDICAL HISTORY

Review of Systems (Problems 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_____
❑ ❑ Weight Gain_____
❑ ❑ Chronic Fever_____
❑ ❑ Anesthetic Reaction_____
❑ ❑ Birth Complications_____
❑ ❑ Childhood Illness_____

2) Eyes
No Yes
❑ ❑ Visual Problems_____
❑ ❑ Double Vision_____

3) Head/Ear Nose & 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_____
❑ ❑ Neck Pain_____
❑ ❑ Back Pain_____

9) Integument
No Yes
❑ ❑ Skin Problems_____
❑ ❑ Skin Lesion_____
❑ ❑ MRSA_____

10) Neurologic
No Yes
❑ ❑ Head Injury_____
❑ ❑ Seizures_____
❑ ❑ Headaches_____
❑ ❑ Loss of Consciousness_____

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_____

Medical History (List medical illnesses, chronic conditions, and hospitalizations you have had)

❑ **NO MEDICAL HISTORY**

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

Surgical History (List any surgeries that you have had)

Have you been told to take antibiotics before surgery or dental work? ❑YES ❑NO

❑ **NO SURGICAL HISTORY**

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

Current Medications (List all prescribed medications as well as all "over-the-counter" medications, vitamins, herbals and supplements)

❑ **NOT TAKING ANY MEDICATIONS**

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

Medication Reactions / Allergies (List each reaction which has occurred)

❑ **NO KNOWN ALLERGIES** **LATEX ALLERGY? ❑YES ❑NO**

	Medication / Substance	Reaction	Date of Occurrence
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			

Family History (Please mark all boxes and add details in blanks regarding health status or cause of death in immediate family)

❑ Heart Disease_____	❑ Anesthetic Reaction_____	❑ Hereditary Diseases_____
❑ High Blood Pressure_____	❑ Deafness_____	❑ Cancer_____
❑ Diabetes_____	❑ Allergy_____	❑ Other_____
❑ Stroke_____	❑ Hay Fever_____	❑ _____
❑ Bleeding Disorder_____	❑ Asthma_____	❑ _____
_____	❑ Thyroid Disorder_____	❑ _____
_____	❑ Kidney Disease_____	❑ _____

Social History (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			

Patient Signature_____ Date_____