Alliance ENT & Hearing Center, S.C.
GENERAL PATIENT HISTORY FORM

PATIENT NAME: _____ **DATE OF BIRTH:** _____

MEDICATION ALLERGIES? ☐ **No Known Drug Allergies**

List any DRUG reactions and SIDE EFFECTS experienced (e.g. shortness of breath, swelling, itching, hives, nausea, vomiting, diarrhea):

_____

_____

LIST ALL MEDICATIONS YOU ARE TAKING OR ATTACH LIST (Prescription and Over-the-Counter) ☐ **None**

Medication	Dosage	How Often Taken		Medication	Dosage	How Often

MEDICAL HISTORY: Have you ever been diagnosed with any of the following? ❑ **No Medical History**

❑ Anesthesia Reaction	❑ Cancer – Type: _____	❑ Hepatitis	❑ Heart Disease	❑ Sickle Cell Disease
❑ Asthma	❑ Diabetes	❑ High Blood Pressure	❑ HIV or Aids	❑ Tuberculosis
❑ Bleeding Disorder	❑ Gastroesophageal Reflux	❑ High Cholesterol	❑ Sleep Apnea	❑ Thyroid Disease

SURGICAL HISTORY: Please check next to any EAR, SINUS, NOSE, THROAT Surgeries. ❑ **No ENT Surgical History**

EAR	*SINUS*	*NOSE*	*Throat*
❑ Ear Tubes	❑ Balloon Sinuplasty	❑ Septoplasty (Deviated Septum)	❑ Tonsillectomy
❑ Tympanoplasty (Ear Drum)	❑ Traditional Sinus Surgery	❑ Rhinoplasty (Nose Reconstruction)	❑ Adenoidectomy
❑ Mastoidectomy (Mastoid)		❑ Turbinate Reduction	❑ Tracheostomy
		❑ Nasal Polyp Removal	❑ Excision of Neck Mass
		❑ Nasal Fracture Repair	❑ Tonsil / Palate Surgery
			❑ Laryngoscopy

If applicable, please list other EAR, NOSE, or THROAT surgeries:

_____

_____

FAMILY HISTORY:

❑ Anesthesia Reaction	❑ Bleeding Disorder	❑ Diabetes	❑ Heart Disease	❑ High Blood Pressure	
❑ Asthma	❑ CVA (Stroke)	❑ Hearing Loss	❑ High Cholesterol	❑ Cancer – Type: _____	❑ Other: _____

SOCIAL HISTORY:

Marital Status	***Employment Status:***
❑ Single ❑ Married ❑ Divorced ❑ Widowed	❑ Child/Student ❑ Employed ❑ Unemployed ❑ Retired ❑ Disabled

Do you wear a pacemaker or defibrillator? ❑ Yes ❑ No

Tobacco Use?	Exposed to second hand smoke?	Alcohol Consumption?	Drug Use–Marijuana, Heroin, Cocaine
❑ Yes ❑ No ❑ Former	❑ Yes ❑ No	❑ None ❑ Occasional ❑ Often	❑ Yes ❑ No

REVIEW OF SYSTEMS: Please check box if experiencing any of the following symptoms or check "None" for no symptoms.

General Health
- ❑ NONE
- ❑ Fatigue
- ❑ Fever
- ❑ Night Sweats
- ❑ Weight Loss/Gain
- ❑ Trouble Sleeping
- ❑ Loss of Appetite

Eye
- ❑ NONE
- ❑ Change in Vision
- ❑ Itchy/Watery Eyes
- ❑ Light Sensitivity
- ❑ Double Vision

Ear
- ❑ NONE
- ❑ Drainage
- ❑ Hearing Loss
- ❑ Infections
- ❑ Itchiness
- ❑ Ear Pain
- ❑ Tinnitus (Ringing in Ear)

Blood or Lymp Nodes
- ❑ NONE
- ❑ Easy Bleeding/Bruising
- ❑ Anemia

Nose & Sinus
- ❑ NONE
- ❑ Congestion/Blockage
- ❑ Facial Pain/Pressure
- ❑ Difficulty Breathing
- ❑ Nose Bleeds
- ❑ Sneezing
- ❑ Stuffy Nose
- ❑ Runny Nose
- ❑ Post Nasal Drainage
- ❑ Sinus Infections

Mouth & Throat
- ❑ NONE
- ❑ Difficulty Swallowing
- ❑ Sleep Apnea
- ❑ Snoring
- ❑ Sore Throat
- ❑ Throat Clearing
- ❑ Hoarseness
- ❑ Sores/Ulcers in Mouth

Glands & Hormone
- ❑ NONE
- ❑ Heat Intolerance
- ❑ Cold Intolerance
- ❑ Swollen Glands

Cardiovascular
- ❑ NONE
- ❑ Heart Murmur
- ❑ Chest Pain
- ❑ Swelling of Ankles/Edema
- ❑ Blacking Out
- ❑ Irregular Heartbeat
- ❑ Palpitations

Respiratory
- ❑ NONE
- ❑ Cough
- ❑ Frequent Colds/Bronchitis
- ❑ History of Pneumonia
- ❑ Shortness of Breath
- ❑ Wheezing

Allergy
- ❑ NONE
- ❑ Food Allergies
- ❑ Insect Allergies
- ❑ Seasonal Allergies
- ❑ Hay Fever
- ❑ Drug Allergies

Musculoskeletal
- ❑ NONE
- ❑ Muscle Aches/Cramps
- ❑ Joint Swelling or Pain

Stomach
- ❑ NONE
- ❑ Abdominal Pain
- ❑ Diarrhea
- ❑ Heartburn/Indigestion
- ❑ Nausea/Vomiting

Brain or Nervous System
- ❑ NONE
- ❑ Headache
- ❑ Seizures
- ❑ Dizziness
- ❑ Numbness
- ❑ Nerve Pain

Skin
- ❑ NONE
- ❑ Itchy Skin/Pruritis
- ❑ Rash
- ❑ Hives/Welts
- ❑ Dry Skin
- ❑ Contact Allergy

PEDIATRIC HISTORY: (Complete if Patient is UNDER 18)

Was patient born premature? (# of WKS _____)	❑ Yes ❑ No
Require intubation or oxygen after delivery?	❑ Yes ❑ No
Was child breastfed? (If so, how long? _____)	❑ Yes ❑ No
History of eczema or food intolerance as kid?	❑ Yes ❑ No
Has your child had any feeding /dietary problems?	❑ Yes ❑ No
Any difficulties with growth or weight gain?	❑ Yes ❑ No
Does child have noisy breathing?	❑ Yes ❑ No
Family history of alcohol, tobacco, or drug use?	❑ Yes ❑ No
Has your child had any of the following delays?	❑ Walking ❑ Learning ❑ Talking

IMMUNIZATIONS:

Are your immunizations current?	❑ Yes ❑ No
Do you receive annual flu vaccines?	❑ Yes ❑ No

FEMALE PATIENTS ONLY

Chance of Pregnancy?	❑ Yes ❑ No
Currently Breastfeeding?	❑ Yes ❑ No

Patient / Guardian Signature: _____ **Date**: _____

Physician Review: _____ **Date**: _____