MIDWEST
EAR, NOSE & THROAT
"Feel Better"

2315 W. 57th Street
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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.

Patient's Last Name_____ First _____ MI _____

Sex ❑ Male ❑ Female Date of Birth: _____

Name of Primary Care Physician: _____

Pharmacy Preference (include location): _____

REASON FOR TODAY'S VISIT: _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

(Include aspirin, ibuprofen, vitamins, fish oil, over the counter meds)

Name of Medication	Dosage	How Often Taken	Why do you take it?

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

Name of Medication	Type of Reaction

SIGNIFICANT MEDICAL HISTORY: (Mark if you have ever had any of the following medical conditions)

❑ Heart Disease ❑ Diabetes ❑ High Blood Pressure ❑ Immune Deficiency
❑ Heart Attack ❑ Clotting Disorders ❑ Thyroid Disease ❑ Rheumatoid Arthritis
❑ Stroke ❑ Atrial Fib ❑ Restless Leg Syndrome ❑ Cancer
❑ Other _____

SURGERIES AND HOSPITALIZATIONS:

Have you ever had problems with being put to sleep (anesthesia)? ____Yes ____No

Any history of Malignant Hyperthermia? ____Yes ____No

Any difficulty with coming out of anesthesia following procedure? ____Yes ____No

List any surgeries you have had (including dates):

_____

_____

_____

List hospitalizations for non-surgical reasons:_____

_____

Currently pregnant? ____Yes ____No

CURRENT OR MOST RECENT OCCUPATION: _____

Name of Person completing form: _____ Today's Date_____

Patient Health History

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DIRECTION OF FEED

Marking Instructions

- Use only a number 2 pencil.
- Fill in the complete oval as shown below.

Correct Mark ● Incorrect Marks ✓ ✗

Name: _____

Date of Appt: _____

1. Are you allergic to any of the following?

	Yes		Yes
Adhesive tape	○	Metal	○
Iodine	○	Seafood	○
Latex	○	Contrast Dye	○

2. Mark if you have been diagnosed with any of the following:

	Yes		Yes
Breast Cancer	○	Gastrointestinal Reflux	○
Lung Cancer	○	Hepatitis	○
Skin Cancer	○	Stomach Ulcer	○
Throat Cancer	○		
Prostate Cancer	○		
Other Cancer	○	Are you pregnant?	○
		Prostate Enlargement	○
Migraine Headache	○	Renal Failure	○
Cataracts	○	Stroke	○
Glaucoma	○		
		Anxiety	○
Nasal Allergies	○	Depression	○
Sleep Apnea	○	Diabetes	○
		Thyroid Dysfunction	○
Blood Clots/DVT	○		
High/Elevated Cholesterol	○	Anemia	○
		Hemophilia	○
Heart Attack	○		
High Blood Pressure	○	HIV	○
Asthma	○		
Chronic Bronchitis	○		
Emphysema	○		
Tuberculosis	○		

3. Mark family members who have been diagnosed with any of the following:

	None	Mother	Father	Brother	Sister
Problems with Anesthesia	○	○	○	○	○
Thyroid Cancer	○	○	○	○	○
Lung Cancer	○	○	○	○	○
Unspecified Cancer	○	○	○	○	○
Hearing Loss before age 20	○	○	○	○	○
Hearing Loss after age 20	○	○	○	○	○
Heart Disease	○	○	○	○	○
High Blood Pressure	○	○	○	○	○
Asthma	○	○	○	○	○
Stroke	○	○	○	○	○
Diabetes	○	○	○	○	○
Bleeding/Clotting Problem	○	○	○	○	○

4. Mark if retired. Yes ○

5. Tobacco Use:
Mark your tobacco use.

○ None ○ Cigarettes
○ Smokeless Tobacco ○ Cigars

Give the closest amount of cigarettes you smoke in an average day.

○ 1/2 pack ○ 2 packs
○ 1 pack ○ 3 packs
○ 1 1/2 packs

Alcoholic Beverages - *A drink is 1 shot of liquor or 1 glass of wine or 1 bottle/can of beer.*

○ Less than 12 drinks/yr
○ 1-13 drinks/mo
○ 4-14 drinks/wk
○ >2 drinks/day

6. Do you use drugs recreationally? Yes ○

7. Caffeine Use (coffee, tea, chocolate, cola, other caffeinated drinks):

○ None ○ 2-3 per day
○ 1 per day ○ 4 or more

8. Are you exposed to second hand smoke? Yes ○

9. Mark if patient attends daycare. Yes ○

10. Will you accept transfusion of blood products if necessary? Yes ○

11. Home Living Situation (mark all that apply).

○ Alone ○ With spouse
○ With children ○ In nursing home
○ With mother ○ With father
○ In assisted living ○ Other

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12. Do you now have or have you recently had any of the following?

	Yes
Fever	○
Sleeping problems	○
Unintentional weight loss	○
Unintentional weight gain	○
Blurred vision	○
Itchy eyes	○
Loss of vision	○
Painful eye	○
Dizziness	○
Ear drainage	○
Hearing loss	○
Ear pain	○
Ringing in the ears	○
Nasal congestion	○
Frequent nosebleeds	○
Post-nasal drainage	○
Belching sour material into throat	○
Hoarseness or other voice changes	○
Mouth ulcers	○
Partials or dentures	○
Blacking out or fainting	○
Chest pain	○
Heart murmur	○
Irregular heartbeats	○
Leg cramps	○
Swelling of ankles	○
Frequent non-productive cough	○
Frequent productive cough	○
Shortness of breath	○
Snoring (excessive)	○
Wheezing	○
Abdominal pain	○
Diarrhea	○
Heartburn	○
Nausea	○
Trouble swallowing	○
Painful swallowing	○
Vomiting	○
Painful joints	○
Stiffness in joints	○
Swelling of joints	○

12. Do you now have or have you recently had any of the following? *(continued)*

	Yes
Change in sense of smell	○
Change in sense of taste	○
Headache	○
Severe face pain	○
Seizures	○
Tremor	○
Appetite is increased	○
Fatigue	○
Cold feeling	○
Bleed excessively after injury	○
Bruise easily	○
Masses (lumps) in armpit	○
Masses (lumps) in neck	○
Masses (lumps) in groin	○
Hives	○
Sneezing	○