

# Ear, Nose & Throat Specialists, LLC Patient History

Name: \_\_\_\_\_

Briefly describe reason for visit: \_\_\_\_\_

\_\_\_\_\_

Symptoms for how long? \_\_\_\_\_

Prior treatment for this problem: \_\_\_\_\_

\_\_\_\_\_

Have you ever been diagnosed or treated with any of the following: (check all that apply)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Nasal Surgery          | <input type="checkbox"/> Asthma                      | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Sinus Surgery          | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Heart Attack        |
| <input type="checkbox"/> Nasal Trauma           | <input type="checkbox"/> Emphysema                   | <input type="checkbox"/> Heart valve problem |
| <input type="checkbox"/> Ear Surgery            | <input type="checkbox"/> Stomach Ulcers              | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> CAT scan sinus or head |  | <input type="checkbox"/> Pacemaker           |
| <input type="checkbox"/> Cancer of _____        | <input type="checkbox"/> Sleep Apnea                 |  |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Sleep Study                 | <input type="checkbox"/> Liver Disease       |
| <input type="checkbox"/> Radiation Therapy      | <input type="checkbox"/> Hypothyroid                 | <input type="checkbox"/> Anemia              |
| <input type="checkbox"/> Daily ASPIRIN use      | <input type="checkbox"/> Bleeding or bruising easily | <input type="checkbox"/> Anesthesia Reaction |

**Current Medications:** (include aspirin, blood thinners, vitamins, herbal, birth control)

\_\_\_\_\_

\_\_\_\_\_

List all **Surgeries:** \_\_\_\_\_

\_\_\_\_\_

**Allergies :** (include allergies to medication, contrast or dyes, latex, iodine)

\_\_\_\_\_

**Smoker?** 1) If Yes → Packs per day \_\_\_\_\_ # of years? \_\_\_\_\_ 2) Quit \_\_\_\_\_ What Year? \_\_\_\_\_

3) Never smoked \_\_\_\_\_ 4) Snuff or Chewing Tobacco \_\_\_\_\_ 5) Cigar or Pipe \_\_\_\_\_

Do you drink beer, wine or liquor on a daily basis? Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_

Patient Signature

\_\_\_\_\_

Date