Primary Health Medical Group

ENT Patient History Form

Name:	**Date of Birth:**
Date:	**Patient's Preferred Name:**
Who referred you to us?	
Occupation:	
Special Interests:	
Exposed to: □ Cigarette/cigar smoke □ Animals/Pets □Toxic Chemicals	

Substance Use: □ None

□ Tobacco _____ years. Daily amount _____ Quit years ago_____

□ Alcohol daily amount _____

Do you/have you had a drinking problem? □Yes □ No

□ Recreational drugs type and frequency _____

I desire help with substance abuse □Yes □ No

Please check yes or no next to <u>each</u> item. If an entire category/system does not apply, check none next to that category.

<u>Head/Eyes</u>	None □	
	<u>Yes</u>	<u>No</u>
Visual Changes	□	□
Light Sensitivity	□	□
Blurred Vision	□	□
Double Vision	□	□
Headaches	□	□

<u>ENT</u>	None □	
	<u>Yes</u>	<u>No</u>
Sores in mouth or throat	□	□
Face or neck lumps	□	□
Nose Bleeds	□	□
Teeth/Gum Disease	□	□

<u>Respiratory</u>	None □	
	<u>Yes</u>	<u>No</u>
Asthma	□	□
Cough	□	□
T.B.	□	□
Wheezing	□	□
Emphysema	□	□
Coughing up Blood	□	□
Sleep Apnea	□	□

<u>Cardiovascular</u>	None □	
	<u>Yes</u>	<u>No</u>
High Blood Pressure	□	□
Chest Pain	□	□
Palpitations	□	□
Heart Attack YR _____	□	□
Irregular Heart Beat	□	□

<u>Musculoskeletal</u>	None □	
	<u>Yes</u>	<u>No</u>
Hand/Foot Swelling	□	□
Back or neck problems	□	□

<u>Skin</u>	None □	
	<u>Yes</u>	<u>No</u>
Bruising	□	□
Rashes	□	□
Skin Lesions or abnormalities	□	□

<u>Gastrointestinal</u>	None □	
	<u>Yes</u>	<u>No</u>
Stomach Pain or Ulcers	□	□
Weight Gain	□	□
Weight Loss	□	□
Dysphasia	□	□
Nausea	□	□
Acid Reflux	□	□
Vomiting	□	□
Diarrhea	□	□

<u>Blood/Lymph</u>	None □	
	<u>Yes</u>	<u>No</u>
Blood Clots	□	□
Bleeding Disorder	□	□
Easy Bleeding	□	□
HIV Concerns	□	□

<u>Psychiatric</u>	None □	
	<u>Yes</u>	<u>No</u>
Depression	□	□
Anxiety	□	□
Mental Disorder	□	□

<u>Endocrine</u>	None □	
	<u>Yes</u>	<u>No</u>
Heat or Cold Intolerance	□	□
Electrolyte Disorder	□	□
Immune Disorder	□	□
Hepatitis	□	□
Diabetes	□	□

<u>Neurological</u>	None □	
	<u>Yes</u>	<u>No</u>
Seizures	□	□
Muscle Weakness	□	□
Numbness/Tingling	□	□
Dizziness/Instability	□	□
Light Headedness	□	□
Sleep Disorder	□	□

	<u>Yes</u>	<u>No</u>
<u>Other</u>	□	□
_____		
_____		
_____		
_____		
_____		

Allergies/Intolerances

□ Medication □ X-Ray Dye

□ Pollen □ Food

□ Soaps/Lotions □ Environment

□ Adhesives □ None

□ Other: _____

List substances & reaction:

_____

_____

Medications	**Dose**	**Taken Since**

Non-Prescription Drugs Taken:

Current Doctors	**Specialty**

Med Condition	**Active?**

Surgeries	**When?**

Other Health Issues:

Family History (blood relatives)

□ Heart Disease

□ Cancer

□ Diabetes

□ Stroke

□ Bleeding Disorder

□ Anesthesia Problems

□ Other

Patient's Signaure:

_____