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

Allergies/Intolerances

☐ Medication	☐ X-Ray Dye
☐ Pollen	☐ Food
☐ Soaps/Lotions	☐ Environment
☐ Adhesives	☐ None
☐ Other:_____	

List substances & reaction:

_____

_____

_____

_____

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

Head/Eyes None ☐	Yes	No
Visual Changes	☐	☐
Light Sensitivity	☐	☐
Blurred Vision	☐	☐
Double Vision	☐	☐
Headaches	☐	☐

ENT None ☐	Yes	No
Sores in mouth or throat	☐	☐
Face or neck lumps	☐	☐
Nose Bleeds	☐	☐

Respiratory None ☐	Yes	No
Cough	☐	☐
Wheezing	☐	☐
Coughing up Blood	☐	☐
Snoring	☐	☐

Cardiovascular None ☐	Yes	No
Chest Pain	☐	☐
Palpitations	☐	☐

Musculoskeletal None ☐	Yes	No
Hand/Foot Swelling	☐	☐
Back or neck problems	☐	☐

Blood/Lymph None ☐	Yes	No
Easy Bleeding	☐	☐

Skin None ☐	Yes	No
Bruising	☐	☐
Rashes	☐	☐
Skin Lesions or abnormalities	☐	☐

Gastrointestinal None ☐	Yes	No
Stomach pain	☐	☐
Weight Gain	☐	☐
Weight Loss	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Diarrhea	☐	☐

Psychiatric None ☐	Yes	No
Feelings of:		
Depression	☐	☐
Anxiety	☐	☐

Endocrine None ☐	Yes	No
Heat or Cold Intolerance	☐	☐

Neurological None ☐	Yes	No
Muscle Weakness	☐	☐
Numbness/Tingling	☐	☐
Dizziness/Instability	☐	☐
Light Headedness	☐	☐

Do you have or have you been treated for any of the following:

None ☐

	Yes	No		Yes	No
Teeth/Gum Disease	☐	☐	Trouble Swallowing	☐	☐
Asthma	☐	☐	Acid Reflux	☐	☐
T.B.	☐	☐	Blood clots	☐	☐
Emphysema	☐	☐	Bleeding Disorder	☐	☐
Sleep Apnea	☐	☐	HIV Concerns	☐	☐
High Blood Pressure	☐	☐	Mental Disorder	☐	☐
Heart Attack YR ____	☐	☐	Electrolyte Disorder	☐	☐
Irregular Heart Beat	☐	☐	Hepatitis	☐	☐
Ulcers	☐	☐	Diabetes	☐	☐
			Seizures	☐	☐

Other Health Issues:

Family History (blood relatives)	
Heart Disease	☐
Cancer	☐
Diabetes	☐
Stroke	☐
Bleeding Disorder	☐
Anesthesia Problems	☐
Other	☐

Medications	Dose	Since
_____		
_____		
_____		
_____		
Non-Prescription Drugs:	Dose	Since
_____		
_____		
_____		

Current Doctors	**Specialty**
_____	
_____	
_____	

Surgeries	**When?**
_____	
_____	
_____	
_____	

*Patient's Signature:*_____

Please stop here

Physician Signature :_____ Date:_____