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OTOLARYNGOLOGY

ENT - PATIENT HISTORY

PATIENT NAME: _____

WHAT DOCTOR SENT YOU HERE? _____

WHICH MEDICINES ARE YOU ALLERGIC TO? _____

WHY ARE YOU SEEING THE DOCTOR TODAY? _____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

WHAT MEDICATIONS HAVE YOU TAKEN FOR THIS? _____

HAVE YOU BEEN SEEN OR TREATED BY A DOCTOR IN THE PAST 12 MONTHS FOR THIS ? _____

IF SO, WHO? _____

HOW MANY TIMES IN THE LAST 12 MONTHS HAD THIS OCCURRED? _____

ALL MEDICATIONS PRESENTLY TAKING:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PERSONAL MEDICAL HISTORY: PLEASE CHECK ANY CONDITIONS THAT THE PATIENT HAS NOW OR IN THE PAST.

	YES	NO		YES	NO		YES	NO
HEART DISEASE	☐	☐	KIDNEY DISEASE	☐	☐	HYPERTENSION	☐	☐
LUNG DISEASE	☐	☐	LIVER DISEASE	☐	☐	ANEMIA	☐	☐
CANCER	☐	☐	THYROID DISEASE	☐	☐	OTHER _____		
BLEEDING PROBLEMS	☐	☐	DIABETES	☐	☐	_____		

SOCIAL HISTORY:

DO YOU CURRENTLY USE?
IF SO, HOW MUCH AND HOW LONG?

CIGARETTES	☐ YES	☐ NO	_____
CIGARS	☐ YES	☐ NO	_____
CHEWING TOBACCO	☐ YES	☐ NO	_____
SNUFF	☐ YES	☐ NO	_____

HAVE YOU EVER USED?
IF SO, HOW LONG DID YOU USE IT AND WHEN DID YOU QUIT?

ALCOHOL	☐ YES	☐ NO	_____
CIGARETTES	☐ YES	☐ NO	_____
CIGARS	☐ YES	☐ NO	_____
CHEWING TOBACCO	☐ YES	☐ NO	_____
SNUFF	☐ YES	☐ NO	_____

LIST ALL SURGERIES: _____

_____

_____

PLEASE LIST ANY OTHER MEDICAL INFORMATION: _____

_____