

# CROSS TIMBERS EAR, NOSE AND THROAT

## Patient Health History

PATIENT'S NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

### Chief Complaint

What reason are you seeing the doctor today? \_\_\_\_\_

How long have you had the problem? \_\_\_\_\_ How long does this problem last? \_\_\_\_\_  not applicable

How often has this problem bothered you?

all the time       every day       a few times per week       once per week

several times per month       once per month       less than once per month       not applicable

Please rate the severity of this problem:  mildly bothersome       moderately bothersome       severe

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

Do you have pain associated with this problem?       yes       no

If yes, please rate it on a scale of 1 through 10 (1= very mild, 10=severe pain): \_\_\_\_\_

Are there any other ENT issues we might need to address today? \_\_\_\_\_

### Past Medical History

Check if you have a history of any of the following:

#### General

reaction to anesthesia

facial trauma

kidney disease

arthritis

HIV/AIDS

cancer

If yes, what kind \_\_\_\_\_

#### Neurological

migraine headaches

seizures

stroke

#### Respiratory

asthma

emphysema

bronchitis

#### Cardiac

high blood pressure

heart disease

heart attack

heart murmur

#### Gastrointestinal

reflux

ulcers

liver disease

#### Endocrine

diabetes

hyper (high) thyroid

hypo (low) thyroid

Hospitalizations or major illnesses not listed:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Surgeries:

_____	_____	_____
_____	_____	_____
_____	_____	_____

### Drug Allergies

Are you allergic to latex?  No       Yes

Medication:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any medications?  No       Yes

Reaction:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Medications

Please list your CURRENT medications, dose, and frequency (how many times a day you take it):

_____	_____
_____	_____
_____	_____
_____	_____

### Family History

Check if the following problems are seen in your family:

asthma       diabetes       heart disease       high blood pressure       hearing loss

bleeding problems       problems with anesthesia       cancer (what kind) \_\_\_\_\_

Health Status of Parents:

Mother       alive       deceased, cause of death: \_\_\_\_\_

Father       alive       deceased, cause of death: \_\_\_\_\_

Father  alive  deceased, cause of death: \_\_\_\_\_

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

Date: \_\_\_\_\_

### **Social History**

Have you ever smoked cigarettes?  yes  no If yes: Up to \_\_\_\_\_ packs per day for \_\_\_\_\_ years

I quit in the year \_\_\_\_\_  I have not quit

Do you use other forms of tobacco?  yes  no If yes: What kind? \_\_\_\_\_

How long did you use? \_\_\_\_\_  Quit, how long ago? \_\_\_\_\_

Do you drink alcohol?  yes  no If yes: How many single drinks per week? \_\_\_\_\_

Have you had a problem with alcohol in the past?  yes  no

Do you or have you ever used IV or illegal drugs?  yes  no

Are you at risk for HIV and/or AIDS? (example: sexual orientation, IV drug use, multiple blood transfusions)  yes  no

Are your immunizations up to date?  yes  no If no, please explain: \_\_\_\_\_

What is your occupation? \_\_\_\_\_

For children: Parents smoking?  yes  no Attends day care?  yes  no Grade in school \_\_\_\_\_

### **Environmental Allergy History**

Do you have "allergies"?  yes  no When?  spring symptoms  fall symptoms  all year symptoms

Have you been tested in the past?  yes  no If yes, when tested \_\_\_\_\_

Have you had allergy shots in the past?  yes  no If yes: Currently getting shots?  yes  no If no, when stopped \_\_\_\_\_

If you have environmental/food allergies, what are you allergic to? \_\_\_\_\_

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### **Review of systems**

Please check only if you have the symptom currently

#### **Constitutional**

- fever
- weight loss
- weight gain
- daytime sleepiness

#### **Eyes**

- double/blurred vision
- itchy eyes
- drooping eyelids
- blindness

#### **ENT**

- hearing loss
- prominent ears
- runny nose
- nasal congestion
- postnasal drip
- hoarseness

#### **Cardiovascular**

- chest pain
- swollen ankles
- irregular pulse

#### **Respiratory**

- snoring
- wheezing
- short breath on exertion
- chronic cough

#### **GI**

- difficulty swallowing
- heartburn/indigestion
- abdominal pain
- jaundice (yellow eyes, skin)

#### **Genitourinary**

- blood in urine
- women: pregnant
- women: trying to become pregnant

#### **Musculoskeletal**

- muscle weakness
- joint pain

#### **Skin/Breast**

- rashes
- concerning skin lesion
- breast lump

#### **Neurologic**

- tremor/hand shaking
- headaches
- difficulty sleeping
- off balance
- memory loss
- difficulty speaking

#### **Endocrine**

- excessive thirst
- excessive hunger
- always cold
- always warm

#### **Hematologic/Lymph**

- easy bruising
- prolonged bleeding
- lump(s) in neck

#### **Psychiatric**

- depression
- anxiety

The above information is accurate to the best of my knowledge.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_