

North Valley Ear, Nose & Throat INITIAL MEDICAL HISTORY

Date _____

M.A. _____

To our Patients:

Thank you for completing the following confidential history form. It will help us greatly in the overall evaluation of your problem. We will develop your history further in a few minutes in the examining room. Until then and thereafter, if you have any questions of our staff, please don't hesitate to ask.

Name _____ Age _____ Birth Date _____
Last First Middle Initial Male Female

Referred to this office by: _____ Currently under the care of a physician? Yes No

If yes, whom? _____ For what diagnosis? _____

For what problem did you come to see the doctor today? _____

Have you been treated for an ear, nose, or throat problem before? Yes No M.D.'s Name _____

If yes, describe the previous problem: _____

List any medications currently taken or applied whether prescribed, over the counter or home remedy types: _____

Are you allergic to any medications? Yes No If yes, please list: _____

Are you currently using tobacco? Yes No If yes, how much? _____ How long? _____

If no, have you ever used tobacco? No Yes

If yes, how much? _____ How long? _____ When did you quit? _____

History of drug abuse? Yes No History of alcohol use? Yes No If yes, how much? _____

Previous surgeries: _____

Any past history of: (If YES, please check and elaborate briefly below.) (If NONE, please check here)

- | | | | | | |
|------------------------------------|-------------------------------------|--|--|--|--------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Liver Trouble/Hepatitis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Other |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Eye Disease | <input type="checkbox"/> Bruising Easily | |

Explain: _____

General/Constitutional: NL ABN

- Alert, oriented
- Vocal quality

Head/Face:

- Parotid & submandibular glands
- Facial strength

Ears:

- Ext. auditory canals
- Tympanic membranes

Nose:

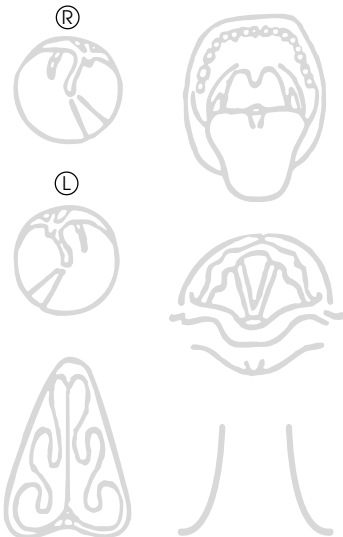
- External appearance of nose
- Nasal septum
- Turbinates

Oral Cavity/Oropharynx:

- Lips, Teeth, Gingiva
- Tonsils

Neck:

- Lymph nodes
- Thyroid



Impression: _____

Plan: _____

Letter: Yes No

DR. _____