

North Valley Ear, Nose, and Throat
PATIENT HISTORY

Date _____

M.A. _____

Time In _____

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 do not hesitate to ask.

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

Referred to this office by: _____ Primary Care Physician: _____

Specialists treating you: _____

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

List any recent x-rays, labs or tests related to your visit: (type, date, facility, doctor) _____

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

- Asthma Diabetes Heart Trouble High Blood Pressure Bleeding Disorder HIV
- COPD GERD Liver Trouble High Cholesterol Kidney Disease Other

Explain: _____

List any previous surgeries: _____

What PRESCRIPTION medications do you take and why? _____

What other NON-PERSCRIPTION (over the counter, herbal or homeopathic) medications do you take? _____

Are you allergic to any medications? Yes No If Yes, please explain _____

Social History:

Occupation _____ Do you live: Alone W/ Spouse W/ Family W/ Friends Assisted Facility

Do you smoke? Yes No, Have you ever smoked? Yes No How long? _____ yrs. How much? _____ packs/day

When did you quit smoking? _____ Any illicit drug use? _____

Do you drink caffeinated beverages? Yes No, How much? _____ drinks/day; Alcohol? Yes No How much? _____

Family History:

	Age	Diseases/Conditions	Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____

Review of Systems:

Please check any of the following problems you are experiencing:

If none, please check here

- General: Fever weight change fatigue night sweats appetite changes
- Skin: Skin growths rashes itching skin/nail/hair changes
- Lungs: Wheezing chronic cough coughing up blood
- Heart: Chest pain angina swelling of hands/feet
- Gastrointestinal: Heartburn diarrhea nausea/vomiting
- Neurology: Headaches fainting numbness weakness slurred speech migraines
- Psychiatry: Nervousness anxiety depression
- Endocrine: Excessive thirst or urination cold/heat intolerance
- Hematology: Anemia blood clots HIV easy bruising/bleeding
- Other: Previous anesthesia problems