Kentucky Ear, Nose and Throat Patient Health History

Name:_____ **Date of Birth:**_____ **Date:**_____

This section for office use only
Vital Signs: Height:___ft____in Weight:_____ Temp:_____ Pulse:_____ BP ____/____(Adults)

What is the main reason you are being seen at KY Ear, Nose and Throat?_____

Have you or any family member ever been seen at our office before? □ **Yes Name:**_____
□ **No**

1. **PAST AND CURRENT MEDICAL HISTORY:**
Have you/the patient been diagnosed with any of the following? Check all that apply.

Bleeding Problems	□	Heart Disease	□	Kidney Disease	□	Others (List):
Anesthesia Problems	□	Congestive Heart Failure	□	Renal Failure	□	
Breast Cancer	□	Heart Attack	□	Anxiety	□	
Lung Cancer	□	High Blood Pressure	□	Depression	□	
Skin Cancer	□	Stroke	□	Memory Problems	□	
Throat Cancer	□	Blood Clots/DVT	□	Diabetes	□	
Prostate Cancer	□	Asthma	□	Thyroid Dysfunction	□	
Other Cancer (List)	□	Emphysema	□	Arthritis	□	
		Tuberculosis	□	Osteoporosis	□	
Migraine Headache	□	Gastrointestinal Reflux	□	Anemia	□	
Seizure Disorder	□	Stomach Ulcer	□	Hemophilia	□	
Glaucoma	□	Hepatitis	□	HIV	□	
Sleep Apnea	□	Enlarged Prostate	□			

2. **TOBACCO USE:** □ None □ Quit (date) _____ Still use: □ Cigarettes □ Smokeless/Chew □ Cigars □ Pipe
Check the amount of tobacco you use(d) each day. □ ½ pack/ can □ 2 packs/ cans
□ 1 pack/ can □ 3 packs/ cans
How many years did/have you smoked? _____ □ 1½ packs/ cans □ more than 3 packs/cans

3. Are you/the patient exposed to **second hand smoke**? □ Yes □ No

4. **ALCOHOL USE:** □ None (A drink is 1 shot of liquor, 1 glass of wine, or 1 bottle/can of beer.)
□ Less than 1 drink/month □ 1-15 drinks/month □ 4-14 drinks/week □ More than 2 drinks/day

5. Will you/the patient accept transfusion of **blood products** if necessary? □ Yes □ No

6. Does the patient **attend daycare**? □ Yes □ No

7. **HOME LIVING SITUATION:** Check all that apply.
□ Alone □ With mother □ With father □ With spouse □ With siblings □ With children
□ In nursing home □ In assisted living □ In foster care □ With significant other □ Other

8. **FAMILY HISTORY:** Check which family members have had the following:

	None	Mother	Father	Sister	Brother	Other (List)
Problems with Anesthesia	□	□	□	□	□	□
Thyroid Disease	□	□	□	□	□	□
Thyroid Cancer	□	□	□	□	□	□
Throat Cancer	□	□	□	□	□	□
Unspecified Cancer (List)	□	□	□	□	□	□
Hearing loss before age 20	□	□	□	□	□	□
Hearing loss after age 20	□	□	□	□	□	□
Heart Disease	□	□	□	□	□	□
High Blood Pressure	□	□	□	□	□	□
Asthma	□	□	□	□	□	□
Stroke	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□
Kidney Problems	□	□	□	□	□	□
Bleeding/Clotting Problems	□	□	□	□	□	□

Name:_____

9. **REVIEW OF SYSTEMS:** Check any symptoms that you /the patient have now or have recently had.

Fever	□	Nasal Congestion	□	Frequent Cough	□
Sleeping Problems	□	Nasal Obstruction	□	Night Time Cough	□
Unintentional Weight Loss	□	Clear Nasal Drainage	□	Shortness of Breath	□
Feeling Cold	□	Colored Nasal Drainage	□	Excessive Snoring	□
Hives	□	Post Nasal Drainage	□	Witnessed Sleep Apnea	□
Blurred Vision	□	Poor Sense of Smell	□	Wheezing	□
Loss of Vision	□	Frequent Nosebleeds	□	Painful Joints	□
Itchy or Watery Eyes	□	Sneezing	□	Headache	□
Painful Eyes	□	Hoarseness or Voice Changes	□	Severe Facial Pain	□
Balance Problems	□	Change in Sense of Taste	□	Seizures	□
Whirling/Spinning Sensation	□	Dentures / Partial Plates	□	Bleed Excessively After an Injury	□
Hearing Loss	□	Heartburn	□	Bruise Easily	□
Ringing/Extra Noises in the Ear	□	Belching Sour Material into Throat	□	Masses (lumps) in Neck	□
Ear Pain	□	Trouble Swallowing	□	Others (List):	
Ear Drainage	□	Painful Swallowing	□		

10. **ALLERGIES:** Are you allergic to any of the following? Check all that apply.
□ Latex □ Adhesive Tape □ Contrast Dye □ Iodine □ Seafood □ Metal

11. **DRUG ALLERGIES:** □ NONE

	Name of Medication	What happens when you take this medication?
1		□ Itching □ Rash □ Nausea □ Shortness of Breath □ Anaphylaxis
2		□ Itching □ Rash □ Nausea □ Shortness of Breath □ Anaphylaxis
3		□ Itching □ Rash □ Nausea □ Shortness of Breath □ Anaphylaxis
4		□ Itching □ Rash □ Nausea □ Shortness of Breath □ Anaphylaxis
5		

12. **CURRENT MEDICATIONS:** □ NONE

	Name of Medication	Strength? (mg)	How many times a day?	Reason for taking it
1				
2				
3				
4				
5				
6				
7				
8				
9	Please bring these medications	with you on your	first appointment	
10	**Nasal Spray**: □ None □ Astelin □ Flonase □ Nasonex □ Nasocort AQ □ Rhinocort Aqua □ Afrin			

13. **PAST SURGICAL HISTORY:** (Include all operations that you have had)

	Name of Operation	Date	Reason	Doctor	Hospital
1					
2					
3					
4					
5					
6					

14. **OCCUPATION**:_____ □ Retired

Your pharmacy is? _____ Notes: _____

Address: _____ _____

Phone number: _____ _____

This form was completed by: _____ Date: _____

Relationship to patient: □ Self □ Mother □ Father □ Daughter □ Son □ Other (specify)_____