

Ear Nose & Throat Past Medical History Intake Form

Patient's name: _____

Family physician: _____ Referring physician: _____

Chief Complaint - explain the main reason why you are here today:

Review of Systems - check all that apply

- | | |
|--|---|
| <input type="checkbox"/> headaches | <input type="checkbox"/> nosebleeds |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> excessive bleeding |

Past Medical History - check all current medical illnesses

- | | |
|---|---|
| <input type="checkbox"/> hypertension (high blood pressure) | <input type="checkbox"/> kidney disease |
| <input type="checkbox"/> coronary artery disease | <input type="checkbox"/> stroke |
| <input type="checkbox"/> myocardial infarction (heart attack) | <input type="checkbox"/> seizures |
| <input type="checkbox"/> atrial fibrillation | <input type="checkbox"/> sleep apnea |
| <input type="checkbox"/> irregular heart rate | <input type="checkbox"/> Down syndrome |
| <input type="checkbox"/> diabetes mellitus | <input type="checkbox"/> autism |
| <input type="checkbox"/> asthma | <input type="checkbox"/> cancer - type? _____ |
| <input type="checkbox"/> emphysema (COPD) | <input type="checkbox"/> bleeding disorder |
| <input type="checkbox"/> bronchitis | <input type="checkbox"/> _____ |

Medication Allergies - provide a list to the medical assistant or list them below:

Family History - check all that apply

- | |
|---|
| <input type="checkbox"/> heart disease |
| <input type="checkbox"/> diabetes mellitus |
| <input type="checkbox"/> cancer (type?) _____ |
| <input type="checkbox"/> bleeding disorder |

Social History

- | |
|---|
| <input type="checkbox"/> non-smoker |
| <input type="checkbox"/> current smoker |
| <input type="checkbox"/> former smoker (year quit?) _____ |

Medications - provide a list to the medical assistant or list them below:

Past Surgical History - check all previous surgeries

- | | |
|--|--|
| <input type="checkbox"/> heart surgery | <input type="checkbox"/> tonsillectomy |
| <input type="checkbox"/> heart stent placement | <input type="checkbox"/> adenoidectomy |
| <input type="checkbox"/> pacemaker | <input type="checkbox"/> thyroid surgery |
| <input type="checkbox"/> sinus surgery | <input type="checkbox"/> _____ |
| <input type="checkbox"/> nasal surgery | <input type="checkbox"/> _____ |
| <input type="checkbox"/> ear tubes | <input type="checkbox"/> _____ |