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

- ☐ headaches
- ☐ shortness of breath
- ☐ nosebleeds
- ☐ excessive bleeding

Past Medical History - check all current medical illnesses

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

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

_____

_____

Family History - check all that apply

- ☐ heart disease
- ☐ diabetes mellitus
- ☐ cancer (type?) _____
- ☐ bleeding disorder

Social History

- ☐ non-smoker
- ☐ current smoker
- ☐ former smoker (year quit?) _____

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

_____

_____

_____

_____

Past Surgical History - check all previous surgeries

- ☐ heart surgery
- ☐ heart stent placement
- ☐ pacemaker
- ☐ sinus surgery
- ☐ nasal surgery
- ☐ ear tubes
- ☐ tonsillectomy
- ☐ adenoidectomy
- ☐ thyroid surgery
- ☐ _____
- ☐ _____
- ☐ _____