



METRO ENT ASSOCIATES PATIENT HEALTH HISTORY

We need to obtain your complete medical history, so it is important for you to fill out this form as completely as possible. This is very important information. Please complete every item. Your doctor needs to know that you have carefully reviewed every area of this form. This information will be entered into your medical record.

Full Name _____ Male Female Date of Birth _____

Pharmacy Preference (include location) _____

Primary Care Physician _____ Referring Physician _____

Reason for visit _____ Date of Visit _____

(Current Medications)

Are you taking ANY kind of medication now? No Yes If yes, please list below *include dosages*.
(This includes prescription, over-the-counter medicines including nasal sprays, or herbal medications)

Medication Name	Dosage	How often taken

(Medication Allergies)

ARE YOU ALLERGIC TO ANY MEDICATIONS? No Yes If yes, please list below.

Name of Medication	Type of Reaction

(Non-Medication Allergies) Are you allergic to anything in the environment such as grass, dust, food, etc.? No Yes
If yes, please indicate what you are allergic to.

Have you ever had an allergy test? No Yes

(Past Health History) Have you ever been *DIAGNOSED* with any of the following problems?

- Cancer (type) _____ No Yes
- Nose and Sinus:
 - Nasal Allergies No Yes
- Heart and Blood Vessels:
 - High / Elevated Cholesterol No Yes
 - High Blood pressure No Yes
- Lungs and Respiratory:
 - Tuberculosis No Yes
- Stomach and Digestive:
 - Duodenal ulcer No Yes
 - Hepatitis No Yes
 - Stomach ulcer No Yes
- Genitourinary:
 - Renal failure No Yes

- Are you pregnant? No Yes
- Mental & Emotional:
 - Anxiety No Yes
 - Depression No Yes
- Glands, Hormones, and Sugar Control:
 - Diabetes No Yes
 - Thyroid deficiency No Yes
 - Thyroid excess No Yes
- Blood & Lymph Node problems:
 - Anemia No Yes
- Allergies, Immune & Infectious Problems:
 - HIV No Yes
 - Infectious mononucleosis No Yes

(Surgeries and Hospitalizations)

Have you ever had any problems with anesthesia? No Yes

If yes, please list what sort of problems. _____

Have you ever had ear, nose or throat surgery? No Yes

If yes, list any surgeries and when they were done. _____

Have you been hospitalized for a medical problem before? No Yes

If yes, list hospitalizations, the reason for admission and the date _____

(Family History)

Specific Anesthesia Problem Mother Father Brother Sister

Cancer:

Lung Cancer Mother Father Brother Sister

Ears:

Hearing Loss before age 20 Mother Father Brother Sister

Hearing Loss after age 20 Mother Father Brother Sister

Nose and Sinus:

Nasal Allergies Mother Father Brother Sister

Heart and Blood Vessels:

Heart Disease Mother Father Brother Sister

Hypertension Mother Father Brother Sister

Lungs and Respiratory:

Asthma Mother Father Brother Sister

Brain and Nervous:

Stroke Mother Father Brother Sister

Blood & Lymph Node problems:

Bleeding/clotting problem Mother Father Brother Sister

Other _____ Mother Father Brother Sister

(Social History)

What is or was your occupation? _____ Check here if you are retired.

Have you ever used tobacco in any form? No Yes

If yes, please complete the following:

Type of Tobacco	From year	To year
Cigarettes per day: _____		
Other: (list type) _____		

Do you consume alcohol? No Yes

If yes, please complete the following:

Type of Alcohol	How Much	How often

Do you use drugs recreationally? No Yes If yes, please list _____

Are you exposed to second hand smoke? No Yes

(Review of Systems): Mark yes or no and CHECK any of the following you have recently had

Constitutional Symptoms No Yes

(fever, sleeping problems, unintentional weight loss)

Eye problems No Yes

(double vision, itchy eyes)

Ears, Nose, Mouth and Throat problems No Yes

(dizziness, ear drainage, hearing loss, ear pain, ringing, chronic congestion, post-nasal drainage, hoarseness/change in voice, snoring, sore throat, ulcers)

Cardiovascular No Yes

(blacking out or fainting, bluish discoloration of lips or fingernails, chest pain, irregular heartbeat, leg cramps, swelling of ankles)

Respiratory problems No Yes

(freq non-productive cough, freq productive cough, shortness of breath, wheezing)

Gastrointestinal problems No Yes

(abdominal pain, diarrhea, heartburn, nausea, vomiting)

Musculoskeletal problems No Yes

(neck pain)

Neurological problems No Yes

(headache, numbness, severe face pain, seizures, weakness)

Problems with Endocrine No Yes

(appetite increased, increased fatigue, feel hot when others do not, feel cold all the time, neck has enlarged, unwanted weight change)

Problems with Hematological/Lymphatic No Yes

(bleeds excessively after injury, bruises easily, neck masses or lumps)

Allergic, Infectious, Immunologic Problems No Yes

(food intolerances, hives, severe reaction to insect bites, frequent sneezing)