EAR, NOSE & THROAT ASSOCIATES OF SOUTH FLORIDA

Medical History Form

Name and city of physician requesting consult: ____

1. Primary Reason for this office visit: ____
2. How long have you had the problem: ____
3. How severe is the problem (circle) *mild 1 2 3 4 5 6 7 8 9 10 severe*
4. How often does it occur constant comes and goes ________________________________
5. What makes it better: ____
6. What makes it worse: ____
7. What other symptoms are you having: ____

Major Medical Illness: (Please check any illnesses you have)

High blood pressure	Anesthesia Reactions	Neuropathy	HIV
Heart disease	GERD	Neck/Back disease	Immune disorder
Heart attack	Stomach ulcer	Pancreatitis	Bleeding disorder
High Cholesterol	Arthritis	Kidney disease	Cancer inc. Skin
Asthma	Fibromyalgia	Kidney stones	(type and treatment)
Emphysema/COPD	Tuberculosis	Depression	____________________
Stroke	Hepatitis	Bipolar Disease	____________________
Diabetes	Liver disease	Anxiety	Other:_____________
Thyroid disease	Atrial Fibrillation	Glaucoma	Other:_____________
Sleep apnea	Heart valve disease	Cataracts	Other:_____________

Previous Operations: (Please check any procedures you have had)

Rhinoplasty	Sinus surgery	Back/spine surgery	Prostate removal
Facelift	Gall bladder removed	Carotid surgery	Organ transplant
Tonsillectomy	Appendix removed	Heart surgery	Gastric bypass
Adenoidectomy	Lung surgery	Coronary Stent	Colon surgery
Ear tubes	Kidney surgery	Carotid Artery Surgery	Abdominal surgery
Other ear surgery	Brain surgery	Eye surgery	Other:_____________
Septoplasty	Joint replacement	Thyroid surgery	Other:_____________

Current Medications (Including Aspirin/Herbal medicines/Over the counter medications):

Name___________________Dose_____________ Name___________________Dose_____________
Name___________________Dose_____________ Name___________________Dose_____________
Name___________________Dose_____________ Name___________________Dose_____________
Name___________________Dose_____________ Name___________________Dose_____________

Do you take Aspirin? Yes No
Do you take Coumadin? Yes No
Have you taken steroids in the last year? Yes No

Allergies to medications, foods and environmental causes:

Name__________________Reaction____________ Name__________________Reaction____________
Name__________________Reaction____________ Name__________________Reaction____________

Family History: (Please check any illnesses that run in your family)

High blood pressure	Stomach ulcer	Kidney disease	Bleeding problems
Heart Attack	Arthritis	Poor Circulation	Sickle cell anemia
Stroke	Anesthesia Reactions	Depression	Cancer (list type)
Diabetes	Heart valve disease	Psychiatric Illnesses	____________________
Thyroid disease	Alcoholism	Immune disorders	____________________

Other:____

Social History: Married Single Divorced Widowed Number of Children _______________
Occupation____________________________________
Smoking: Prior use? Yes No Current use? Yes No How many cigarettes per day ________
Alcohol consumption? Yes No How many drinks per day______________
Caffeine consumption? Yes No How many caffeinated beverages per day______________
Recreational drugs: Prior use? Yes No Current use? Yes No
List any street drugs you formerly or currently use____

Review of Symptoms: (Circle all that apply)
CONSTITUTIONAL Fatigue Weight Loss Fever Chills Negative
EYES Eye Pain Double Vision Loss of Vision Negative
EARS Hearing Loss Ringing in Ears Ear Pain Drainage Dizziness Blockage Negative
NOSE Obstruction Congestion Drainage Bleeding Facial Pressure/Pain Negative
THROAT Sore mouth/throat Lump in Throat Voice Change Difficulty/Pain with Swallowing Negative
NECK Pain Masses Negative
CARDIOVASCULAR Chest Pain Palpitations Poor Circulation Negative
RESPIRATORY Cough Shortness of Breath Wheezing Negative
INTESTINAL Nausea/Vomiting Diarrhea Pain Negative
GENITOURINARY Urinary difficulty Pain with Urination Negative
MUSCULOSKELETAL Bone or Joint Pain Neck/Spine Pain Negative
SKIN Sensitivity to tape, iodine or latex Negative
NEUROLOGIC Memory Loss Loss of Feeling Paralysis of Face Paralysis of leg/arm Negative
PSYCHIATRIC Depression Anxiety Nervousness Hallucinations Negative
HEMATOLOGIC Bleeding Problem Negative
ENDOCRINE High Sugars Thyroid problem Negative
ALLERGIC Itchy eyes Runny Nose Sneezing Itchy ears Negative
INFECTIONS DISEASES Hepatitis Tuberculosis HIV/Aids Mononucleosis Negative
FEMALE PATIENTS: Are you pregnant? No Yes (Number of weeks: ____)

Have you had any tests or studies relevant to today's visit? If yes, please note these below:
XRAY/CT/MRI ________________________________ Part of body:_________________________
Blood tests ____________________________________
Biopsy results __________________________________

Who is your Primary Care Physician?
Full Name:____________________________________
Address: _____________________________________
____

I have personally reviewed this history and review of systems.
Signature _____________________________________ Date _____________