

## PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS

Many ear, nose and throat problems or treatments are affected by other health problems or medications. Please help us by answering the following questions.

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

Regular Doctor \_\_\_\_\_

### REVIEW OF SYSTEMS

• Have you ever had any of the following medical problems? (please circle yes or no)

Heart Attack .....	No Yes	Emphysema .....	No Yes	Unplanned Weight Loss .....	No Yes
Heart Failure .....	No Yes	Coughing up Blood .....	No Yes	Enlarged Lymph Nodes .....	No Yes
Chest Pain Related to Heart Disease .....	No Yes	Tuberculosis .....	No Yes	Free Bleeding .....	No Yes
Other Heart Problems .....	No Yes	Pneumonia .....	No Yes	Blood Thinner Treatment .....	No Yes
High Blood Pressure .....	No Yes	Severe Heart Burn .....	No Yes	Anesthesia Problems .....	No Yes
Poor Circulation .....	No Yes	Hiatal Hernia .....	No Yes	Depression and/or Anxiety .....	No Yes
High Cholesterol .....	No Yes	Stomach Ulcers .....	No Yes	Auto-Immune Disorders .....	No Yes
Stroke .....	No Yes	Hepatitis .....	No Yes	Skin Disorders Including Skin Cancers .....	No Yes
Paralysis .....	No Yes	Jaundice(Whites of eyes turn yellow) .....	No Yes	Eye Disorders .....	No Yes
Severe Headaches .....	No Yes	Kidney Infection .....	No Yes	Hearing Loss .....	No Yes
Seizures .....	No Yes	Other Kidney Problems .....	No Yes	Prostate Problems(Men) .....	No Yes
Blackout Spells .....	No Yes	Thyroid Problems(like goiter) .....	No Yes	<b>Cancer</b> .....	<b>No Yes</b>
Head Injury .....	No Yes	Diabetes .....	No Yes	When _____	
Meningitis(Infection around brain) .....	No Yes	Arthritis/ Joint Pain .....	No Yes	What Type _____	
Asthma .....	No Yes	Fevers for Extended Periods .....	No Yes		

### PAST HISTORY

• Please list any other medical problems not listed above.


• Please list any previous **SURGERIES**

Surgery	Date

Are you **ALLERGIC** to?

(Please circle yes or no)

Penicillin? .....	No Yes
Sulfa? .....	No Yes
“Mycins”? .....	No Yes
Aspirin? .....	No Yes
Codeine? .....	No Yes
Tetanus? .....	No Yes
Demerol? .....	No Yes
Other Medicine (list)? .....	No Yes
Other Things (list)? .....	No Yes

• Do you **SMOKE**? ..... No Yes

If yes, how much and how often? \_\_\_\_\_

• Have you **EVER SMOKED** or used tobacco? ..... No Yes

If yes, how much and how often? \_\_\_\_\_

• Do you drink **ALCOHOL**? ..... No Yes

If yes, how much and how often? \_\_\_\_\_

### Family History

Allergy? .....	No Yes
Heart Disease? .....	No Yes
High Blood Pressure? .....	No Yes
Stroke? .....	No Yes
Diabetes? .....	No Yes
Bleeding Problem? .....	No Yes
Tuberculosis? .....	No Yes
Cancer? .....	No Yes
Anesthesia Problems? .....	No Yes
Hearing Loss? .....	No Yes

• Please list any **MEDICATIONS** you are currently taking below.


Initial \_\_\_\_\_