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CONNECTICUT
EAR•NOSE•THROAT
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MEDICAL HISTORY REVIEW

Name:__________ **D.O.B.**__________ **Acct #:**__________

Age:__________ ❑ **Male** ❑ **Female** **Date:**__________

REASON FOR TODAY'S VISIT: __________

Duration of Problem:__________

Prior tests or treatments for this problem: (i.e. X-rays, CT Scans, MRI, Hearing Test, etc.) ❑ Allergy Tested Y N Year_____

Nurses Notes:__________

MEDICATIONS: ❑ **none**

Please list medications currently taking including over-the-counter & supplements:__________

ALLERGIES TO MEDICATIONS: ❑ **none** ❑ **allergic to penicillin** ❑ **allergic to Iodine/Shellfish** ❑ **contrast dye**

Others - List:__________

ENT

Do you presently have any of the following symptoms?

EARS ❑ ***No problems***

	R	L
Ear infection	❑	❑
Drainage	❑	❑
Pain/Pressure	❑	❑
Hearing Loss	❑	❑
Hearing aid	❑	❑
Ringing or buzzing	❑	❑
Itching	❑	❑

Dizziness ❑ Spinning ❑ Lightheaded ❑

New onset Y N

History of noise exposure ❑

Head trauma ❑

Last Hearing Test__________

Where__________

Other:__________

NOSE ❑ ***No problems***

	R	L
Bleeding/Nose bleeds	❑	❑
Congestion	❑	❑
Post nasal drip	❑	❑
Sinus problems	❑	❑
Headaches	❑	❑

❑ Loss of sense of smell

❑ Currently being treated by allergist:
Dr.__________

❑ Food Allergies
(i.e., strawberries, shellfish)
____

❑ Environmental Allergies
(i.e., seasonal, pet, dust)

Other:__________

THROAT ❑ ***No problems***

❑ Throat clearing
❑ Swallowing difficulties
❑ Throat pain
❑ Cough
❑ Hoarseness
❑ Neck Swelling ❑ R ❑ L
❑ Snoring
❑ Apnea/Breath holding
❑ CPAP
❑ Daytime Sleepiness
❑ Fatigue
❑ Awakens at night
❑ Restlessness

Other:__________

PLEASE COMPLETE THE OTHER SIDE → → → →

Name ______________________ DOB ______________ Acct ______________

General Info & Social History

Height: ______ Feet ______ Inches

Weight: ______ Pounds

Occupation: ______________

Disabilities: ______________________________

Tobacco ❑ Yes ❑ No ❑ Previous smoker ❑ 2nd hand smoke exposure

(Including chewing tobacco, pipe & cigars) # of years ______ # of packs/day ______

Alcohol Number of drinks/week ______ Quit smoking year ______

Visual Disabilities: Macular Degeneration ❑ Yes ❑ No Glaucoma ❑ Yes ❑ No Are you Claustrophobic? ❑ Yes ❑ No

❑ Pregnant/Considering Pregnancy ❑ Metal in body or exposure to metal ______________
(hip replacement, knee)

Hematologic Disorders

❑ ***No Problems*** ❑ HIV ❑ Hep C

❑ Yes

If yes, explain: ______________

❑ History of pulmonary emboli

❑ Anemia ❑ Bruising concerns

❑ Von Willibrand Disease or family H/O

❑ Phlebitis ❑ Clotting Disorder

Cancer History

❑ ***No Problems***

❑ Type of cancer ______________

And where ______________

❑ Year: ______________

❑ History of chemo

❑ History of radiation

Gastro/Intestinal

❑ ***No Problems***

❑ Ulcers

❑ Reflux

❑ Heartburn Frequency ______

❑ Nausea/Vomiting

❑ Irritable Bowel

❑ Medications for the problem

____

Heart

❑ ***No Problems***

❑ Chest Pain

❑ History of heart attack Year ______

❑ Coronary artery disease

❑ Mitral valve prolapse

❑ High blood pressure

❑ Pacemaker/Defibrillator

❑ Heart procedures (i.e. stent, angioplasty)

____

Lungs

❑ ***No Problems***

❑ Asthma

❑ Cough

❑ Coughing up blood

❑ Shortness of breath

❑ Oxygen Therapy

❑ COPD

❑ Other

Metabolic Disorders

❑ ***No Problems***

❑ Diabetes ❑ Lyme Disease

❑ Thyroid ❑ Arthritis

❑ Autoimmune ❑ Polycystic Ovary Syndrome

Neurologic

❑ ***No Problems***

❑ Anxiety

❑ Migraines

❑ Seizures

❑ Depression

❑ Stroke ______________

❑ Multiple Sclerosis

❑ Parkinson's

❑ Dementia/Alzheimers

❑ Other: ______________

Urinary System

❑ ***No Problems***

❑ Frequent urination

❑ Prostate

❑ Decreased kidney function

❑ Dialysis

Surgeries

❑ ***None***

List surgeries: ______________

____

____

❑ Anesthesia complications

What happened? ______________

Family Health History

❑ ***No Problems*** ❑ Anethesia Complications ❑ Malignant hyperthermia

How is the health of your immediate family? Include any ear, nose and throat problems

Father: ______________________________

Mother: ______________________________

Sibling(s): ______________________________

Patient Signature: ______________________ Date: ______________

Reviewed by: Dr. ______________________ Nurse: ______________