HISTORY FORM

E·N·T of ATHENS

PCP / Referring Physician: _____

Name: _____ DOB: _____

What is the reason for your visit today? (Please describe your symptoms) _____

_____

_____

How long have you had these symptoms? _____ Are you currently pregnant? ❑ YES ❑ NO

Have you had any of the following: ❑ Allergy Testing WHEN & WHERE _____

❑ Imaging Scans WHEN & WHERE _____ ❑ Lab Tests / Cultures WHEN & WHERE _____

❑ Ultrasounds WHEN & WHERE _____ ❑ Sleep Studies WHEN & WHERE _____

Past Medical History:

❑ Nasal Allergies
❑ Asthma
❑ Coronary Artery Disease
❑ Atrial Fibrillation
❑ High Blood Pressure
❑ MRSA
❑ Heart Failure
❑ Diabetes
❑ Reflux
❑ ADD/ADHD
❑ HIV
❑ Hepatitis C
❑ Eczema
❑ Thyroid Disorder
❑ Heart Attack
❑ Autoimmune Disorder
❑ Stroke
❑ Kidney Disease
❑ Bleeding Disorder
❑ Heart Murmur
❑ Hearing Loss
❑ Sleep Apnea
❑ Meniere's Disease
❑ Problems with Anesthesia
❑ Cancer (what site?) _____
❑ Other _____

Previous Surgeries and Dates:

	DATE:		DATE:		DATE:		DATE:
❑ Tubes in ears	_____	❑ Dental surgery	_____	❑ Pacemaker	_____	❑ Septoplasty	_____
❑ Cancer surgery	_____	❑ Ear drum repair	_____	❑ Hysterectomy	_____	❑ Sinus surgery	_____
Type: _____		❑ Heart bypass	_____	❑ Joint replacement	_____	❑ Tonsillectomy	_____
❑ Carotid surgery	_____	❑ Heart stent	_____	❑ Mastoidectomy	_____	❑ Adenoidectomy	_____
❑ Cervical spine surgery	_____			❑ Neck Mass Removal	_____	❑ Thyroidectomy	_____

❑ Other _____

Family History:

❑ Allergy ❑ Asthma ❑ Bleeding Disorder ❑ High Blood Pressure ❑ Heart Disease ❑ Hearing Loss ❑ Problems with Anesthesia ❑ Thyroid Disorder ❑ Cancer (what type)? _____ ❑ Diabetes

Social History: (please indicate quantity consumed where necessary)

❑ Tobacco Products ❑ Never ❑ Past How long? _____ How much? _____

❑ Alcohol Use:
❑ Never ❑ Weekly
❑ Daily ❑ Occasionally

❑ Personal Use of Recreational Drugs? ❑ NO ❑ YES

Review of Symptoms: (Please check all symptoms experienced in the last 7 days.)

Constitutional:	❑ Fevers ❑ Chills	❑ Weight Loss	❑ Fatigue
Eyes:	❑ Changes in vision	❑ Blurred vision	❑ Excessive tearing
Cardiovascular:	❑ Swelling of extremities	❑ Heart murmur	❑ Light-headedness
Respiratory:	❑ Shortness of breath	❑ Cough	❑ Wheezing ❑ Hoarseness
Gastrointestinal:	❑ Vomiting	❑ Constipation	❑ Diarrhea ❑ Heartburn
Skin:	❑ Rash	❑ Itch	❑ Changes in mole or skin
Neurologic:	❑ Speech difficulties	❑ Seizure	❑ Loss of Consciousness
Musculoskeletal:	❑ Limitation of motion	❑ Muscular weakness	❑ Arthritis ❑ Loss of Balance
Hematologic-Lymphatic:	❑ Easy bleeding	❑ Known bleeding disorders	
Allergic-Immunologic:	❑ Sinus allergy symptoms	❑ Allergic dermatitis	❑ Frequent Illness