BELLEVUE EAR, NOSE & THROAT CLINIC

Adult Patient History Form

Date: ___/___/________

Name: ________________________________ Date of Birth: ___/___/________

Referring Doctor:____________________ Primary Care Physician:____________________

Medication Allergies: ☐No Known Allergies ☐Latex Allergy

____________ Reaction: ____________ ____________ Reaction: ____________
____________ Reaction: ____________ ____________ Reaction: ____________
____________ Reaction: ____________ ____________ Reaction: ____________

Current Medications: ☐None

____________ Dosage: _____ | ____________ Dosage: _____ | ____________ Dosage: _____
____________ Dosage: _____ | ____________ Dosage: _____ | ____________ Dosage: _____
____________ Dosage: _____ | ____________ Dosage: _____ | ____________ Dosage: _____
____________ Dosage: _____ | ____________ Dosage: _____ | ____________ Dosage: _____
____________ Dosage: _____ | ____________ Dosage: _____ | ____________ Dosage: _____

Surgical History:

________________ Date: ________ ________________ Date: ________
________________ Date: ________ ________________ Date: ________
________________ Date: ________ ________________ Date: ________

Medical Hospitalizations:

________________ Date: ________ ________________ Date: ________
________________ Date: ________ ________________ Date: ________

PATIENT Medical History:

☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Birth Disorder
☐ Bleeding Disorder
☐ Cancer type:__________
☐ Chronic infection
☐ Congestive Heart Failure
☐ COPD
☐ Coronary Artery Disease
☐ CVA (stroke)
☐ Depression
☐ Diabetes - type: 1 or 2
☐ Emphysema
☐ GERD (reflux)
☐ ENT syndromes
☐ Headaches
☐ Heart Disease
☐ High Cholesterol
☐ Hypertension (high blood pressure)
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Intestinal Disorder
☐ Irregular heart rate
☐ Glaucoma
☐ Graves Disease
☐ Kidney Disorder
☐ Autoimmune disease
☐ Migraines
☐ Multinodular Goiter
☐ Otosclerosis
☐ Seizure disorder
☐ Sleep Apnea
☐ Stomach ulcer
☐ Tinnitus
☐ Vertigo
☐ Other: ______________

FAMILY Medical History:

☐ Allergies
☐ Asthma
☐ Autoimmune disease
☐ Coronary Artery Disease
☐ Cancer type: __________
☐ Cleft lip / palate
☐ CVA (Stroke)
☐ Depression
☐ Developmental Delay
☐ Diabetes
☐ GERD (Reflux)
☐ Hearing Disorder
☐ Hematological Disorder
☐ Hyperlipidemia
☐ Hypertension
☐ Migraines
☐ Obesity
☐ Chronic Ear infections
☐ Otosclerosis
☐ Renal (kidney) Disease
☐ Seizure Disorder
☐ Sickle Cell Disease
☐ Sleep Apnea
☐ Hypothyroidism
☐ Thyroid Disorder
☐ Other: ______________
☐ Other: ______________

Social History:

Do you smoke? Y N How may packs per day? _____ Number of years: _____ If you quit, when did you quit? ________

Other tobacco use? Y N type: ______________ Recreational drug use? Y N type: ______________

Do you drink alcohol? Y N If yes, how many?_____ how often? _____ type: ______________

Do you drink caffeine? _____ What form? ☐ coffee ☐ tea ☐soda ☐chocolate ☐energy drink ☐tablets How may per day? ______

Occupation: ______________________ Marital status: M S W D

Have you ever been treated for HIV/AIDS? Y N Hepatitis? Y N type: ______________

(TURN OVER TO COMPLETE NEXT PAGE...)

Review of Systems:

Constitutional: ☐ all negative

☐ Chills ☐ Fever ☐ Fatigue ☐ night sweats ☐ weight gain/loss

☐ Other: ____________________

Head, Eyes, Ears, Nose, & Throat: ☐ all negative

☐ blurred vision ☐ dizziness ☐ hearing loss ☐ sore throat

☐ choking on liquids ☐ drooling ☐ hoarseness ☐ ringing in the ears

☐ choking on solids ☐ difficulties swallowing ☐ mouth ulcers ☐ vertigo

☐ double vision ☐ ear drainage ☐ ear pain ☐ visual changes

☐ Other: ____________________

Respiratory: ☐ all negative

☐ shortness of breath ☐ wheezing ☐ snoring ☐ sleep apnea ☐ Other: ____________________

Cardiovascular: ☐ all negative

☐ chest pain ☐ heart murmur ☐ palpitations ☐ pacemaker ☐ Other: ____________________

Gastrointestinal: ☐ all negative

☐ abdominal pain ☐ heartburn ☐ diarrhea ☐ vomiting ☐ constipation

☐ Other: ____________________

Metabolic: ☐ all negative

☐ cold/heat intolerance ☐ increased thirst ☐ Other: ____________________

Neurologic: ☐ all negative

☐ sleep problems- type:__________ ☐ numbness/tingling in hands/feet: ☐ passing out ☐ tremor ☐ weakness ☐ ADHD ☐ Autism

☐ Other: ____________________

Psychiatric: ☐ all negative

☐ anxiety ☐ depression ☐ hallucinations ☐ Other: ____________________

Dermatologic: ☐ all negative

☐ pruritis (itchy skin) ☐ rash ☐ change in mole ☐ lesion on face ☐ Other: ____________________

Hematologic: ☐all negative

☐ bleed easily ☐ bruise easily ☐ enlarged lymph node ☐ abnormal blood tests ☐ blood clots

☐ Other: ____________________

Is there anything else you would like us to know regarding your health?

____

____

____

* Patient / Guardian signature: ____________________ Date: ___ / ___ / ______