

Midwest Ear, Nose & Throat Specialists: Adult

Last name: _____ First name: _____ Age: _____ Acct # _____

Referring MD: _____ Other Physician : _____ Date: _____

Medical History Check (✓) conditions you have had in your lifetime

- | | | |
|--|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Epilepsy/ Seizures | <input type="checkbox"/> Liver: _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> GERD/Reflux | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Arthritis/ Gout | <input type="checkbox"/> Heart: _____ | <input type="checkbox"/> Anxiety/Depression |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid (hyper or hypo) |
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> AIDS/HIV positive | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney: _____ | <input type="checkbox"/> None |
| <input type="checkbox"/> Emphysema/ COPD | <input type="checkbox"/> Migraine Headache | |

Surgical History List all surgeries you have had in your lifetime **No Previous Surgeries**

- | | | | |
|--------|---|---|---------------------------------|
| Ears | <input type="checkbox"/> Ear Tubes | <input type="checkbox"/> Mastoid: | <input type="checkbox"/> Other |
| Nose | <input type="checkbox"/> Septoplasty | <input type="checkbox"/> Sinuses: | <input type="checkbox"/> Other: |
| Throat | <input type="checkbox"/> Tonsil/Adenoid | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Other: |
| Heart | <input type="checkbox"/> Bypass | <input type="checkbox"/> Valve | <input type="checkbox"/> Other: |
| Chest | <input type="checkbox"/> Esophagus | <input type="checkbox"/> Gastric bypass | <input type="checkbox"/> Other |
| GI | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Appendix | <input type="checkbox"/> Other |
| Ortho | <input type="checkbox"/> Back | <input type="checkbox"/> Knee | <input type="checkbox"/> Other |
| Female | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Tubal Ligation | <input type="checkbox"/> Other: |
| Male | <input type="checkbox"/> Prostate | <input type="checkbox"/> Hernia: | <input type="checkbox"/> Other |

Other Major Surgery: _____

Problems with Anesthesia? no: yes (explain): _____

Family History

Check (✓) if your blood relatives have had any of the following

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Anesthesia
problem/high fever | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Early hearing loss | <input type="checkbox"/> Heart disease |
| | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Tuberculosis |

Mother alive deceased Cause of death _____

Father alive deceased Cause of death _____

Social

Marital Status: Married Single Divorced Widowed

Children: Yes No Ages: _____

Pregnant? No Yes Due Date: _____

Healthy Habits

Do you use tobacco? Yes No Exercise regularly? Yes No
Amt: _____ Years: _____ Consume alcohol? Yes No
Ever used tobacco? Yes No Use illegal drugs? Yes No
When did you quit? _____

Occupational

Check (✓) if your work exposes you to the following

- Stress Hazardous substances Environmental allergen
- Heavy lifting Loud Noise
- What is your occupation? _____ Unemployed

Symptoms

*Check (✓) symptoms you **currently have**:*

GENERAL

- Unexplained Fever /Sweats
- Unexplained Weight Loss

EYES

- Blurred vision
- Double vision

ENT

- Difficulty swallowing
- Ear pain/discharge
- Loss of Hearing
- Nosebleeds
- Ringing in ears
- Sinus problems

CARDIOVASCULAR

- Chest pain
- Irregular heart beat
- Heart Murmur

RESPIRATORY

- Persistent cough
- Hoarseness

- Shortness of Breath

MUSCLE/JOINT/BONE

Pain, weakness, numbness
in:

- Arms/Shoulders
- Back/Neck

GENITO-URINARY

- Blood in urine
- Frequent urination

GASTROINTESTINAL

- Excessive hunger/ thirst
- Nausea/ Vomiting
- Stomach pain

NEUROLOGIC

- Chronic Pain
- Headache
- Numbness

PSYCHIATRIC

- Anxiety

- Depression

ENDOCRINE

- Thyroid problems

HEME/LYMPH

- Enlarged Lymph Glands
- Excessive Bleeding

ALLERGY/IMMUNO

- Decreased immunity
- Hay Fever

SKIN

- Changes in moles
- Sore that won't heal

Hospitalizations *List all times you have been hospitalized and the reason for this* None
