Geneva Woods Ear, Nose and Throat Associates, Inc.

ENTSA - EAR, NOSE, THROAT SPECIALISTS ALASKA

PATIENT HEALTH HISTORY FORM

Patient Name: _____ Age: _____ Date of Birth: _____

Occupation: _____ Weight: _____

Name of Physician requesting this consultation: _____

Past History

Please list any prior major illnesses, chronic diseases, syndromes, or conditions and/or injuries:

_____

_____

_____

Surgeries/Hospitalizations ☐ None	Year	Complications

Have you ever had problems with anesthesia? ☐ Yes ☐ No

Current Medication(s) including Aspirin ☐ None	Dose	Frequency

List any allergies/reactions to medications, anesthetics or materials: ☐ None

Family History:

Do you have a family history of trouble with anesthesia? ☐ Yes ☐ No

Do you have a family history of easy bleeding? ☐ Yes ☐ No

Social History:

Do you smoke? ☐ No, I have never smoked. ☐ Yes, I smoke _____ packs of cigarettes per day for _____ years.

☐ No, I quit _____ years ago. At the most I've smoked _____ packs per day for _____ years.

☐ Yes, I smoke cigars or a pipe.

☐ Chewing Tobacco? _____ Can(s) per _____

☐ Exposed to second hand smoke?

Do you drink alcohol? ☐ No, never (or rarely) ☐ No, but I used to. How much? _____

☐ Yes ☐ Daily ☐ 1 or more times a week ☐ 1 or more times a month. How much? _____

Date:_____

Review of Systems
Are you currently, or have you had problems with:

Constitutional

Weight gain	☐ Yes	☐ No
Weight loss	☐ Yes	☐ No
Night Sweats	☐ Yes	☐ No
Insomnia	☐ Yes	☐ No

Eyes

Double Vision	☐ Yes	☐ No
Visual Loss	☐ Yes	☐ No

Ear, Nose, Throat and Mouth

Hearing Loss	☐ Yes	☐ No
Noise/Ringing in ears	☐ Yes	☐ No
Nasal Congestion	☐ Yes	☐ No
Sore Throat	☐ Yes	☐ No
Trouble Swallowing	☐ Yes	☐ No
Hoarseness	☐ Yes	☐ No

Cardiovascular

Chest pain or angina	☐ Yes	☐ No
Heart trouble	☐ Yes	☐ No
Rheumatic fever	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No

Neurological

Numbness	☐ Yes	☐ No
Weakness	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Headache	☐ Yes	☐ No

Psychiatric

Depression	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No

Allergic/Immunologic

Sneezing	☐ Yes	☐ No
Itchy eyes/nose	☐ Yes	☐ No
Itchy throat	☐ Yes	☐ No
Skin Rash	☐ Yes	☐ No
HIV	☐ Yes	☐ No

I have reviewed the above information with the patient.

_____ _____

Physician Signature Date

Respiratory

Asthma	☐ Yes	☐ No
Coughing up blood	☐ Yes	☐ No
TB	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No
Snoring	☐ Yes	☐ No
Trouble breathing At night	☐ Yes	☐ No

Gastrointestinal

Indigestion/Heartburn	☐ Yes	☐ No
Ulcer	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Jaundice (yellowing)	☐ Yes	☐ No
Blood in stool	☐ Yes	☐ No
Black, tarry stools	☐ Yes	☐ No

Genitourinary

Bladder trouble	☐ Yes	☐ No
Prostate disease	☐ Yes	☐ No
Kidney disease	☐ Yes	☐ No

Musculoskeletal

Arthritis	☐ Yes	☐ No

Endocrine

Diabetes	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No

Hematologic

Bleeding Disorder	☐ Yes	☐ No
Easy Bleeding	☐ Yes	☐ No

The above information is accurate to the best of my knowledge.

_____

Patient Name

_____

Patient or Guardian Signature

Date:_____