ENT ASSOCIATES OF ALABAMA, P.A

EAR, NOSE & THROAT
DISEASES OF THE SINUSES
ALLERGY

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PATIENT HISTORY FORM

Name: ____ Age: _________ Occupation: __________________________

Date: _______________________ Sex: ____________ Marital Status: S M W Date of Birth: __________________

Chief Complaint: ____

____

List all Medications Allergies: ____

List other Allergies (Pollens, Dust, etc.):____

List present Medications: ____

Family History

		CAUSE OF DEATH
1. Your Father	Alive _____ Dead _____	________________ ________________
2. Your Mother	Alive _____ Dead _____	________________ ________________ ________________
3. Your Brothers and Sisters TOTAL No.	Alive _____ Dead _____	________________ ________________ ________________

DO YOU HAVE A FAMILY HISTORY OF

	NO	YES
1. Heart Disease	_________	_________
2. High Blood Pressure	_________	_________
3. Diabetes	_________	_________
4. Stroke	_________	_________
5. Cancer (Location)	_________	_________
6. Thyroid Disease	_________	_________
7. Allergies	_________	_________
8. Asthma	_________	_________
9. Hearing Loss	_________	_________
10. Other Diseases:	_________	_________

REVIEW OF YOUR BODY SYSTEMS: Do you have now or have you ever had any of the following?

	NO	YES	PLEASE EXPLAIN
Ulcers			
Colitis			
Rectal Bleeding			
Change in Bowel Habits			
Black Tarry Stools			
Heart Disease			
High Blood Pressure			
Chest Pain			
Cough Blood			
Shortness of Breath			
Thyroid Disease			
Lung Disease			
Cancer (Location)			
Asthma or Emphysema			
Hepatitis			
Gallbladder Disease			
Venereal Disease			
Kidney Stone(s)			
Blood in Urine			
Epilepsy			
Swollen or Painful Joints			
Nervous Disorder			
Depression			
Diabetes			
Stroke			
Back Disorder			
Blood Disease or Anemia			

REVIEW OF EAR, NOSE & THROAT PROBLEMS: Do you have now or have you ever had any of the following?

	NO	YES	PLEASE EXPLAIN
Decreased Hearing			
Ringing in Ear			
Ear Infections			
Dizzy Spells			
Nose Bleeds			
Problems Breathing out of Nose			
Sinus Problems			
Sore Throat			
Hay Fever/Allergies			
Hoarseness/Voice Changing			
Difficulty Swallowing			
Pain in Swallowing			
Heartburn			
Headache			

PERSONAL HISTORY:

Medical Problems (Please Explain): ____

____

Your Hospitalizations:		Year	Hospital
Illness (kind)	____________	______	____________
	____________	______	____________
	____________	______	____________
	____________	______	____________
Surgery (kind)	____________	______	____________
	____________	______	____________
	____________	______	____________
	____________	______	____________

YOUR CHILDREN: Number living: _______ List any serious diseases in children: ______________________

Number diseases children: ___________ Cause: ______________________________

YOUR PERSONAL HABITS: Do you?	Yes	No	Please Explain
Regularly exercise (3 or 4 times a week)	______	______	____________
Use illegal drugs	______	______	____________
Use alcohol	______	______	____________
Were you ever a heavy drinker	______	______	____________
Smoker	______	______	____________
If ever, when did you stop?	______	______	____________

TEST AND IMMUNIZTIONS (Give date last done)

	Yes	Year Preformed	Not Sure	Never	Comments
Chest X-Ray	______	______	______	______	____________
EKG	______	______	______	______	____________
Fasting Blood Sugar	______	______	______	______	____________
Thyroid Profile	______	______	______	______	____________
Tetanus (DPT)	______	______	______	______	____________
Flu Shot	______	______	______	______	____________
PneumoniaVaccine	______	______	______	______	____________