PATIENT PAST HISTORY

DATE: _____

PATIENT NAME: _____ SS# ____/____/____ Age: _____

PRIMARY PHYSICIAN _____

REASON FOR VISIT: _____

DO YOU HAVE: (CHECK ALL THAT APPLY)

EARS: ☐ HEARING LOSS ☐ DRAINAGE ☐ RINGING ☐ ITCHING PAIN ☐ NO EAR PROBLEMS

NOSE/THROAT: ☐ BLEEDING ☐ SINUSITIS ☐ SNEEZING ☐ POST NASAL DRIP ☐ SNORING

☐ HOARSENESS ☐ SWALLOWING ☐ SORE THROAT ☐ HEARTBURN

☐ HIATAL HERNIA ☐ LUMP IN THROAT ☐ VOICE PROBLEM ☐ CHRONIC COUGH ☐ NO NOSE/THROAT PROBLEMS

DIZZINESS: VERTIGO, SENSATION OF SPINNING: _____

(DESCRIBE AND HOW OFTEN)

REVIEW OF SYSTEMS: DO YOU HAVE: ANSWER EACH YES OR NO

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	HEADACHES	☐	☐	SKIN PROBLEMS	☐	☐	NAUSEA	☐	☐	SHORTNESS OF BREATH
☐	☐	VISION LOSS	☐	☐	BOWEL PROBLEMS	☐	☐	ABDOMINAL PAIN	☐	☐	MUSCLE AND/OR JOINT PAIN
☐	☐	NECK PAIN	☐	☐	CHEST PAIN	☐	☐	MEMORY LOSS	☐	☐	URINARY PROBLEMS

MEDICAL HISTORY: DO YOU HAVE OR HAVE EVER HAD: ANSWER EACH YES OR NO

YES	NO		YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	ASTHMA	☐	☐	ULCERS	☐	☐	DEPRESSION	☐	☐	HEART DISEASE	☐	☐	MITRAL VALVE PROLAPSE
☐	☐	BRONCHITIS	☐	☐	DIABETES	☐	☐	ARTHRITIS	☐	☐	HIGH BLOOD PRESSURE			
☐	☐	SEIZURES	☐	☐	KIDNEY DISEASE	☐	☐	THYROID DISEASE	☐	☐	CANCER	☐	☐	OTHER

PAST SURGERIES, ILLNESSES AND HOSPITALIZATIONS, INCLUDE DATES: IF NONE, WRITE NONE

_____

_____

DRUG ALLERGIES: IF YES, LIST SPECIFIC REACTION ☐ NO KNOWN DRUG ALLERGIES

_____

_____

HAVE YOU EVER HAD A REACTION TO A CONTRAST DYE? _____

CURRENT MEDICATIONS AND HOW OFTEN TAKEN:

_____

_____

SOCIAL HISTORY: DO YOU CONSUME ALCOHOL: YES NO # DRINKS PER WEEK _____

DO YOU USE TOBACCO: YES NO # PER DAY ____ # YEARS ____ # YEAR QUIT ____

WHAT IS/WAS YOUR OCCUPATION: _____

ARE YOU EXPOSED TO: NOISE FUMES POLLUTION OUTSIDE ALLERGENS NO EXPOSURES

(CIRCLE ALL THAT APPLY)

DO YOU HAVE RELIGIOUS BELIEFS WHICH PROHIBIT MEDICAL TREATMENTS? YES NO

IF YES, EXPLAIN: _____

PAST FAMILY HISTORY: ANSWER EACH YES OR NO, IF YES , LIST RELATIONSHIP

YES	NO			YES	NO		
☐	☐	HEARING LOSS	_____	☐	☐	HEART DISEASE	_____
☐	☐	ALLERGIES	_____	☐	☐	HIGH BLOOD PRESSURE	_____
☐	☐	THYROID DISEASE	_____	☐	☐	STROKE	_____
☐	☐	RESPIRATORY DISEASE	_____	☐	☐	GASTROINTESTINAL DISEASE	_____
☐	☐	CANCER	_____	☐	☐	DIABETES	_____
☐	☐	OTHER	_____				

_____ _____ MD

SIGNATURE OF PERSON COMPLETING REVIEWED BY